New Hampshire Building Capacity for Transformation 1115 Medicaid Waiver

IDN PROCESS MEASURES SEMI-ANNUAL PROGRESS REPORT

For

Year 5 (CY2020)

2020-12-31

FINAL DRAFT

Introduction

The Centers for Medicare and Medicaid Services (CMS) approved New Hampshire's application for a five-year Medicaid demonstration project to improve access to and the quality of behavioral health services by establishing regionally based Integrated Delivery Networks (IDN) and developing a sustainable integrated behavioral and physical health care delivery system. To achieve the goals of the demonstration waiver, the IDNs are charged with participating in statewide planning efforts and selecting and implementing community-driven projects. These projects are built around three enabling pathways: mental health and substance use disorder treatment capacity building, integration of physical and behavioral care, and improving transitions of care across settings.

Per the Standard Terms and Conditions and contractual requirements Integrated Delivery Networks who have met 100% of the required deliverables will be required to submit ongoing Semi-Annual Progress Reports. It is the expectation that all partners will continue to make progress along the SAMHSA Integrated Care Practice Designation Continuum.

Submission of the semi-annual progress report shall be a single pdf document which includes all attachments. In addition, due to printing and size constraints, your attachments should also be uploaded separately in the original file version as well (MS project, MS excel, etc.). The January-June 2020 semi-annual report is due July 31, 2020 and the July-December 2020 semi-annual report is due January 29, 2021. Attachments should use the naming convention identified in the weekly update dated week ending July 7, 2017. The naming convention shall correlate with the project deliverable

To be considered timely, supporting documentation must be submitted electronically to the State by the dates indicated above into each IDN's semiannual reporting folder. For questions, contact:

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Project Plan Implementation (PPI)

Narrative

Provide a detailed narrative to reflect progress made during this reporting period as it relates to the Administration, Network, and Governance.

Community Input:

(All updates by reporting period shared in bullet format)

Gaining community input has been foundational to all IDN-1 planning since the beginning of the 1115 Waiver program in Region 1. Leaders across IDN-1 recognize the importance of listening to key stakeholders to understand the complexities of the current system of care and of engaging these stakeholders to plan and implement the changes they would like to see. Additionally, the IDN1 Medical Director and Members of the IDN1 Executive Committee participate as Chair and Co-chair of the Community Engagement Research Board for Synergy, resulting in their regular engagement and updates from community voices as well as continuous learning about the value and nature of meaningful community engagement.

Updates for Semi Annual Period: July-December, 2020

- *Expanded upon ongoing efforts of involvement at the project team levels as well as the regional level through Knowledge Exchanges, Advisory Council Meetings, Regional Data and IT Workgroup, Performance Leadership Discussions.*
- *Continued with community member, patient input and engagement at the project level where possible*
- *Continued to attend and engage in community and state events about topics associated with IDN goals such as workforce.*
- *Engage with partners outside of the region to include statewide perspectives and trends affecting region 1 climate.*
- *Continued recruitment and retention activities to ensure partner organization representation across Executive Committee members*
- *Continued participation in the Regional Public Health Network meetings across the IDN1 catchment area*
- *Participation in community forums regarding both funded and non-funded IDN efforts in the IDN1 catchment counties*
- *Participation and engagement with COVID-19 response statewide and within IDN1 organizations*

Network Development:

(All updates by reporting period shared in bullet format)

To date, IDN-1 has been actively building a network of care providers and community supports to address the many needs of the Medicaid members in region 1. The process has been open, inclusive and

consensus-driven. The following updates represent network development and retention activities over the last several months:

Updates for Semi Annual Period: July-December, 2020

- *Given the point in project implementation the IDN is not onboarding new partners. The IDN is always open to new partner engagement and assessing an organizations fit to join the IDN network. This process has been formalized by the IDN executive committee and includes questions for any new onboarding organizations and identifies if the service provided fills a current IDN gap area. This identification and vetting also weighs the organizations Medicaid penetration.*
- *In CY2020 the IDN has expanded network connections in Sullivan County to further facilitate the Sullivan County Complex Care team and support the Greater Sullivan Strong response to COVID-19.*
- *The IDN1 team continues to engage and stay connected with our network partners through one to one connections as well as through our ongoing large group meetings.*

IDN 1 Administration:

In the July-December, 2020 term there were several notifications of change to the IDN Admin Team-

- *Peter Mason, MD, IDN1 Medical Director had his last day with the IDN team on 12/31/2020.*
- *Ashley Greenfield, Sullivan County HUB Manager, gave her notice in December, 2020 and her last day with the IDN team will be 1/8/2021.*
- *Stephanie Cameron, IDN1 Program Manager, gave notice in December, 2020 and will be reducing to .5FTE on 1/8/2021 and to .2FTE on 3/1/2021. Her time will conclude fully with the IDN on 6/30/2021.*
- *Mark Belanger, IDN1 Integration Director, will continue at .5FTE through 3/30/2021 but then will conclude his work with the team.*
- *Jessica Leandri, IDN1 Executive Director, will remain 1FTE through 6/30/2021 but then will conclude or further reduce her time.*
    - *Given the lack of funding and wind down of program work in CY2021 no positions will be rehired.*
- *There is work underway with the Population Health at DH to look at the best options for staff support and program wrap up effort in December, 2021. More will be reported on this in the coming quarters.*

Governance

IDN-1 formalized its governance structure in the late summer of 2016 and it has been in operation ever since. The governance structure is described in detail within the IDN-1 Project plan which was approved by DHHS in the fall of 2016. The following defines the Governance efforts to date, many of which will continue into the future:

Executive Committee Periodic Meetings and Briefings: The IDN-1 Executive Committee is the primary governance body of the IDN. The EC is comprised of 4 community members and 7 institutional members who represent the stakeholders of IDN-1.

Updates for Semi Annual Period: July-December, 2020

- *Christopher Tyler Vogt left his position in Primary Care at Dartmouth Hitchcock in September, 2020 and moved to Burlington, VT. Given this change he was no longer able to support the IDN1 Executive Committee and vacated his seat.*
- *Peter Starkey left his position at Monadnock Peer Support and moved to Oregon in November, 2020. Given this change he was no longer able to support the IDN1 Executive Committee and vacated his seat.*
- *John Manning indicated his intention to retire in June, 2021 and given the increase in work and activity to prepare for that departure notified that he will not be able to continue supporting the IDN EC in CY2021. His last meeting was December, 2020.*
- *The IDN Executive Committee met and discussed the format, committee structure post DSRIP waiver period and the group concluded that to continue with the governance structure as is but meeting quarterly would be the most supportive to the IDN team. A vote was held in the December 10, 2020 meeting on the following: VOTE to revise IDN Governance as follows- In the post waiver period, calendar year 2021, the Executive Committee will continue in its current form, waiving term limits and maintaining a minimum of four representatives. At the point of writing 7 of the current board members have agreed to continue for CY2021.*

Advisory Council Periodic Meetings and Briefings: The IDN-1 Advisory Council is a broad inclusive body that has representation of all stakeholders and partners and that advises IDN-1. The Council has been kept informed and apprised of IDN-1 activity through regular communications, a newsletter, and the IDN-1 website.

Updates for Semi Annual Period: July-December, 2020

- *No Advisory Council Meetings were held in the July-December term but the final AC will be held virtually in late January, 2021. The final session was pushed out to accommodate for the end of our community projects effective 12/31/20 and much of the event will be spent reviewing the successes of the DSRIP in IDN1 and thanking our partners/ project teams.*

Data Governance: IDN-1 launched a Data & IT Workgroup as a sub-committee of the Executive Committee. One function of the Workgroup is data governance. The workgroup has been working through issues of patient privacy including preparedness for information sharing between organizations that serve a single patient's needs.

Updates for Semi Annual Period: July-December, 2020

- *The IDN1 Data & IT workgroup continued to meet and make progress on team targets*

- *The workgroup is sharing all data transparently and identified by organization.*
- *The workgroup continues to review and support the IDN1 overarching data and IT rollout Focus of this group has shifted to center around pay for performance and supporting ongoing communication to partners on this process*
- *The workgroup held their final session in mid-December, 2020*

Budget

Please provide a budget of actual expenditures and projected costs to complement narrative.

Throughout fall, 2020 the IDN1 administrative team undertook an exhaustive review and fiscal audit with the Dartmouth –Hitchcock finance team to ensure all financial tracking and documentation is stored within their system as the wind down of the IDN1 admin team begins in January. The budget below reflects the updated information as of December, 2020. The calendar year closeout within the DH system will not complete until late January. Any budget amendments identified in the year end reporting will be included in subsequent reporting.

As part of the financial review and migration of IDN financial documents into the DH system a few changes were made in regard to reporting that has resulted in shifts to previous term totals. Some high level adjustments are as follows:

- **Alignment of IDN reported Grant Year (GY) to Calendar Year (CY) and Contract Terms to single GY/CY total. This caused some noted change in reporting column totals.**
- **Inclusion of University of New Hampshire Consulting Agreements and costs for Practice Facilitation in Administrative Totals (accounting for roughly $400,000 change)**
- **Transition of HIT consultation time into Administrative totals.**
- **Inclusion of pre-2017 Administrative totals from the previous D-H grants module. Unbeknownst to the IDN staff this migration did not occur at the time of grants module change in CY2017.**

Additional minor re-coding has occurred to align expenses to the correct project bucket in the Accounts Payable system.

Region 1 IDN Profit and Loss - Accrual Basis - As of November 24, 2020									Projected			
	2016 Jul-Dec	2017 Jan-Jun	2017 Jul-Dec	2018 Jan-Jun	2018 Jul-Dec	2019 Jan-Jun	2019 Jul-Dec	2020 Jan-Jun	2020 Jul-Dec	2021 Jan-Jun	2021 Jul-Dec	**Total**
Revenue	**3,617,426**	**2,000,403**	**2,000,404**	**2,015,565**	**1,551,984**	**1,068,962**	**186,762**	-	**46,539**			**12,488,045**
Expenses												
Workforce Investments (A1)				43,557	317,515	217,193	775,615	454,997	242,632	2,400		2,053,909
Information Technology Investments (A2)	56,570	278,378	201,765	364,660	402,434	169,263	180,918	47,534	47,766	11,099		1,760,387
Care Integration Investments (B1)			5,500	164,783	179,195	274,620	631,158	858,460	774,490	461,355		3,349,562
Enhanced Care Coordination Community Investment (C1/E5)			86,129	102,428	94,528	22,465	207,533	1,208	-			514,290
Perinatal Addiction Treatment Program Community Investment (D3)			22,329	78,320	69,946	110,119	90,005	145,883	140,303			656,904
Enhanced Care Coordination Community Investment (E5)			38,381		1,250	1,225		59,577	61,034			161,468
Needs Assessment	30,526	12,000										42,526
Program Administration	1,643	148,358	186,413	290,140	231,009	356,431	297,198	295,410	283,575	175,000		2,265,177
Program Planning	49,403	1,277	637									51,317
Expenses - Subtotal	**138,142**	**440,013**	**541,154**	**1,043,888**	**1,295,877**	**1,151,317**	**2,182,427**	**1,863,068**	**1,549,799**	**649,854**	**-**	**10,855,540**
Fiscal Agent Indirect (15%)	20,721	66,002	81,173	156,583	194,382	172,698	327,364	279,460	232,470	97,478	-	1,628,331
Expenses - Total	**158,863**	**506,015**	**622,327**	**1,200,471**	**1,490,259**	**1,324,015**	**2,509,791**	**2,142,528**	**1,782,269**	**747,332**	**-**	**12,483,871**
Profit / Loss - by Period	3,458,563	1,494,388	1,378,077	815,094	61,725	(255,053)	(2,323,029)	(2,142,528)	(1,735,731)	(747,332)	-	
Profit / Loss - Cumulative	**3,458,563**	**4,952,951**	**6,331,028**	**7,146,122**	**7,207,847**	**6,952,794**	**4,629,765**	**2,487,236**	**751,506**	**4,174**	**4,174**	**4,174**

The updated P&L table is the result of an extensive review with the internal fiscal agent finance team to line up budgets by grant year and calendar year across the lifetime of the waiver. In previous reporting terms due to the discrepancy in reporting from grant year and translated to calendar year some of the totals for 6 month term were not appropriately included.

Project A1: Behavioral Health Workforce Capacity Development

Narrative

Each IDN was required to complete an IDN level Workforce Capacity Development Implementation Plan, inclusive of the workforce needed to complete projects A1, A2, B1 and the IDN selected Projects C, D, and E.

Provide a detailed narrative to reflect progress made**/activity** toward recruitment, retention, hiring and training during this reporting period.

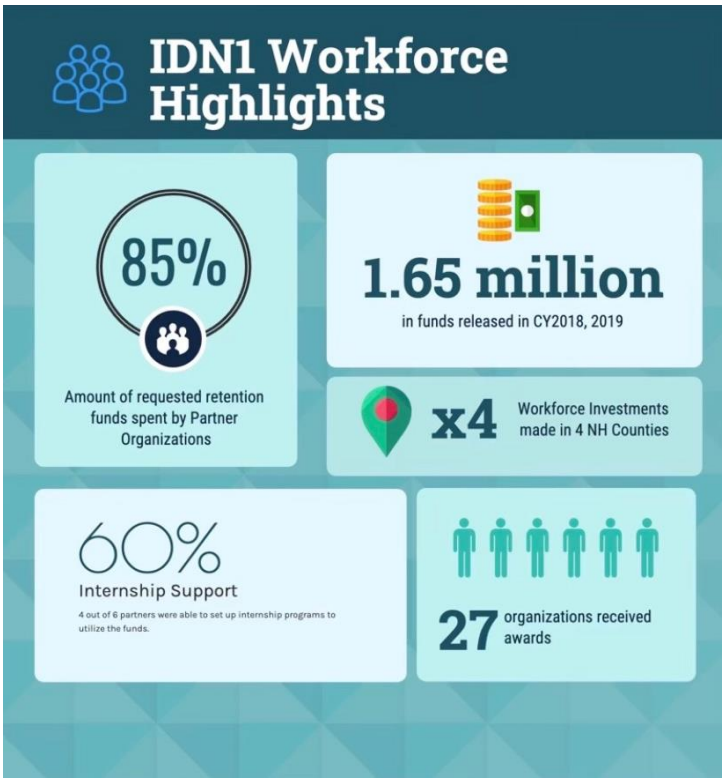
Include in your narrative detail of Key Organizations and Providers that have been off-boarded **as well as new partners/affiliated organizations** and the effective date of the change.

During the July-December, 2020 term the administrative team in IDN1 focused on the wrap up and comprehensive evaluation of IDN workforce awards made over the last four years. As of early fall, 2020 all of the IDN1 workforce awards had been fully expended or expired due to contract timing.

With the majority of workforce awards expiring on June 30, 2020. Much of July and August was spent reviewing the closing WF awards. Once all contract components were closed and materials received for final reporting from the partners in fall, 2020 the IDN team was able to spend time analyzing how the funds were used and where the most notable improvements can be seen in both the organizations and the region. IDN1 released funds across several domains but loan repayment, recruitment, retention and internship/supervision support were the most robust.

Cumulatively in the 2018, 2019 RFA cycles and additional training workforce allocations the IDN released $1,652,386.00 to network partners Due to the reduction in funding in CY2020 there is not a plan in IDN1 for any new release of WF funds in CY2021.

Region 1 IDN analyzed program funding applications and spending and has reached the following conclusions:



Retention: Partners were most able to use funds focused on retention including: HR retention strategy, loan repayment, and retention bonuses. Most (8 of 10) Partners were able to set up the retention programs to utilize the funds. Partners spent ~85% of requested retention funds.

Internships: Partners were somewhat able to use funds focused on interns including: Internships and Organizational Support for Internships. Some (4 of 6) Partners were able to set up the internship programs to utilize the funds. Partners spent ~60% of requested retention funds.

Recruiting: Partners were somewhat able to use funds focused on recruiting including: HR Recruiting Strategy, Sign-On Bonuses, Staff Referral Bonuses, and Relocation Reimbursement. Some (avg. 4 of 7) Partners were able to utilize the funds. Partners spent ~44% of requested retention funds with most focused on Sign On bonuses. Partners were challenged to spend funds on Staff Referrals (only 10% of funds spent) and Relocation Reimbursement (only 5% of funds spent)

Change in IDN1 Network:

- No change in the IDN1 network in the July-December, 2020 term.

A1-7 IDN-level Workforce: Table of Key Organizational and Provider Participants

Use the format below to provide an **updated list of key organizations** and providers participating in the IDN to support workforce development within the reporting period. Include and note workforce related to the IDN HIT Infrastructure, IDN Integrated Healthcare, and the IDN selected community projects.

No change to the key of organizational partners aside from the noted organization removal of Mindful Balance referenced above.

No change in July-December, 2020 term

Organization Name	Organization Type	Associated with IDN Projects (A1, A2, B1, C, D, E)
Alice Peck Day Memorial Hospital	Hospital Facility	A1, A2, B1
Cheshire County (includes :)	County	A1, A2
Behavioral Health Court Program (CCBHCP)	Other County Organization	A1, A2
DOC	County Corrections	A1, A2
Maplewood Nursing Home	County Nursing Facility	A1, A2
Cheshire Medical Center/DHK	Hospital Facility	A1, A2, B1, C1, E5
Child and Family Services	Non CMHC Mental Health Provider	A1, A2, B1
Community Volunteer Transportation Company (CVTC)	Community Based Organization Providing Social and Support Services	A1, A2, C1, E5
Counseling Associates	Non CMHC Mental Health Provider	A1, A2, B1
Crotched Mountain (includes :)	Community Based Organization Providing Social and Support Services	A1, A2,
Adult Residential Services	Adult Residential Services	A1, A2
ATECH Services	Assistive Technology Clinical Consultation	A1, A2
Community Care	Community Care Management	A1, A2, B1
Outpatient Services	Specialty Outpatient Clinics	A1, A2
Crotched Mountain School	Residential Treatment	A1, A2
Dartmouth-Hitchcock Primary Care-Lebanon	Primary Care Practice	A1, A2, B1
Dartmouth-Hitchcock Dept. of Psychiatry	Non CMHC Mental Health Provider	A1, A2, B1, D3
Easter Seals Farnum Center	Other Organization Type	A1, A2
Grafton County (includes :)	County	A1, A2
Senior Citizens Council	Other County Organization	A1, A2
Granite State Independent Living	Home and Community Based Care Provider	A1, A2
Greater Monadnock Public Health Network	Public Health Organization	A1, A2

Greater Sullivan County Public Health Network	Public Health Organization	A1, A2
Headrest, Inc.	Substance Use Disorder (SUD) Provider	A1, A2, B1
Home Healthcare Hospice and Community Services	Home and Community Based Care Provider	A1, A2,C1, E5
Keene Housing	Other Organization Type	A1, A2, C1, E5
Ken Jue Consulting	Other Organization Type	A1, A2
Lake Sunapee VNA	Home and Community Based Care Provider	A1, A2
Lebanon Housing Authority	Other Organization Type	A1, A2
Life Coping Inc.	Non CMHC Mental Health Provider	A1, A2
MAPS	Non CMHC Mental Health Provider	A1, A2
Mary Hitchcock Memorial Hospital	Hospital Facility	A1, A2, B1
Mascoma Community Health Center[1]	Integrated Healthcare Provider (not counted as B1)	A1, A2
Monadnock Area Peer Support Agency	Other Organization Type	A1, A2, C1, E5
Monadnock Center for Violence Prevention	Community Based Organization Providing Social and Support Services	A1, A2
Monadnock Collaborative	Other Organization Type	A1, A2, C1, E5
Monadnock Community Hospital	Hospital Facility	A1, A2, B1
Monadnock Family Services	Community Mental Health Center	A1, A2, B1, C1, E5
Monadnock Region System of Care	Non CMHC Mental Health Provider	A1, A2, C1, E5
NAMI New Hampshire	Non CMHC Mental Health Provider	A1, A2
New London Hospital and Medical Group Practice, Pediatric Care Center Practice, and Newport Health Center	Hospital Facility, Primary Care Practice	A1, A2, B1
Pathways of the River Valley	Home and Community Based Care Provider	A1, A2
Phoenix House	Substance Use Disorder (SUD) Provider	A1, A2, B1
Planned Parenthood of Northern New England - Claremont	Primary Care Practice	A1, A2
Planned Parenthood of Northern New England - Keene	Primary Care Practice	A1, A2
Reality Checks	Other Organization Type	A1, A2
ServiceLink-Grafton County	Other Organization Type	A1, A2
ServiceLink - Monadnock	Other Organization Type	A1, A2, C1, E5
Southwestern Community Services, Inc.	Community Based Organization Providing Social and Support Services	A1, A2, C1, E5

Stepping Stone & Next Step Respite Centers	Peer Support – Mental Health	A1, A2, E5
Sullivan County (includes :)	County	A1, A2
Dept. of Corrections	County Corrections	A1, A2, E5
Maplewood Nursing Home	County Nursing Facility	A1, A2
tlc Family Resource Center (includes The Center for Recovery Resources – formally Hope for Recovery)	Home and Community Based Care Provider	A1, A2, B1, E5
Twin Pines Housing Trust	Other Organization Type	A1, A2
Upper Valley Public Health Council	Public Health Organization	A1, A2
Valley Regional Hospital	Hospital Facility	A1, A2, B1, E5
Visiting Nurse and Hospice for VT and NH	Home and Community Based Care Provider	A1, A2
West Central Behavioral Health	Community Mental Health Center	A1, A2, B1, E5

Staffing All Projects

Provide the IDN's projected and **current number of full-time equivalent** (FTE) staff **related to the IDN HIT Infrastructure, IDN Integrated Healthcare, and the IDN selected community-driven projects**. This table should be the sum of all **statewide and community-driven projects** and also include any IDN administrative staff.

No change in staffing in the July-December reporting period.

Project Code	Provider Type	Projected Total Need	Baseline Staffing on 6/30/17	Staffing on 12/31/17	Staffing on 6/30/18	Staffing on 12/31/18	Staffing on 6/30/19	Staffing on 12/31/19	Staffing on 07/30/20	Staffing on 12/31/20
Admin Team	Executive Director	1FTE	1 FTE	1 FTE	1 FTE	1 FTE	1 FTE	1 FTE	1 FTE	1 FTE
	Medical Director	.5 FTE	.5 FTE	.5 FTE	.5 FTE	.5 FTE	.5 FTE	.5 FTE	.5 FTE	.5 FTE
	Integration Director	.5 FTE						.5FTE	.5FTE	.5FTE
	Program Manager	1 FTE	1 FTE	1 FTE	1 FTE	1 FTE	1 FTE	1 FTE	1 FTE	1 FTE
	HIT Consultants	%	Contracted with MAeHC	Contracted with MAeHC	Contracted with MAeHC	Contracted with MAeHC	Contracted with MAeHC	Contracted with MAeHC		
B1	Care Team Coordinator						1FTE	1FTE	1FTE	1FTE
	APRN						1FTE	1FTE	1FTE	1FTE

	Primary Care Clinicians % FTE						.35FTE	.35FTE	.35FTE	.35FTE
	Supervision % FTE						.1FTE	.1FTE	.1FTE	.1FTE
	Project Manager						.5FTE	.5FTE	.5FTE	.5FTE
	MSW						2.5FTE	2.5FTE	2.5FTE	2.5FTE
	MLADC						1FTE	1FTE	1FTE	1FTE
	CHW						3FTE	3FTE	3FTE	3FTE
D3	Masters Level clinician (BH)	.75 FTE	Recruit to Hire	1.5 FTE	1.5 FTE	1.5 FTE	1.5 FTE	1.5 FTE	1.5 FTE	1.5 FTE
	Psychiatry (MD, ARNP)	.1 FTE	Recruit to Hire	.3 FTE	.3 FTE	.3 FTE	.3 FTE	.3 FTE	.3 FTE	.3 FTE
	OB/GYN(ARNP, CNM)	0 FTE	Recruit to Hire	.1 FTE	.1 FTE	.1 FTE	.1 FTE	.1 FTE	.1 FTE	.1 FTE
	Pediatrician (MD, ARNP)	0 FTE	Recruit to Hire	.1 FTE	.1 FTE	.1 FTE	.1 FTE	.1 FTE	.1 FTE	.1 FTE
	Case Manager	.4 FTE	Recruit to Hire	.5 FTE	.5 FTE	.5 FTE	.5 FTE	.5 FTE	.5 FTE	.5 FTE
	Recovery Coach	.5 FTE	Recruit to Hire	.5 FTE	.5 FTE	.5 FTE	.5 FTE	.5 FTE	.5 FTE	.5 FTE
	Childcare Providers	.3 FTE	Recruit to Hire	.75 FTE	.75 FTE	.75 FTE	.75 FTE	.75 FTE	.75 FTE	.75 FTE
	Administrative Support Staff	0 FTE	Hired, Utilizing Current Staff	.5 FTE	.5 FTE	.5 FTE	.5 FTE	.5 FTE	.5 FTE	.5 FTE
	Certified Medical Assistant	0 FTE	Hired, Utilizing Current Staff	.5 FTE	.5 FTE	.5 FTE	.5 FTE	.5 FTE	.5 FTE	.5 FTE
C1	Care Transition Coordinator	2 FTE	0- In process to Recruit to hire	2 FTE	2 FTE	2 FTE	2 FTE	2 FTE	2 FTE	2 FTE

	Supervisor	1 FTE	In process to reallocate Current Staff % FTE	1 FTE	1 FTE	1 FTE	1 FTE	1 FTE	1 FTE	1 FTE
E5	Enhanced Care Coordinators	2 FTE	0- In process to Recruit to hire	2 FTE	2 FTE	2 FTE	2 FTE	2 FTE	2 FTE	2 FTE
	Community Case Manager	1 FTE	Recruit to Hire	0 FTE*	1 FTE	0	Not Currently Staffed Given Project Restructuring- All Contract Positions	1 FTE	1 FTE	1 FTE
	Supervisor	.1FTE	0.1 FTE, Current Staff: Re-allocated	0.1 FTE, Current Staff: Re-allocated	0.1 FTE, Current Staff: Re-allocated	0.1 FTE, Current Staff: Re-allocated	0.1 FTE, Current Staff: Re-allocated	0.1 FTE, Current Staff: Re-allocated	0.1 FTE, Current Staff: Re-allocated	0.1 FTE, Current Staff: Re-allocated

Budget

Provide a narrative and a brief project budget outlining actual expenditures and projected costs to support the workforce capacity development implementation plan which must include financial reporting on actual spending to recruit, hire, train, and retain the workforce.

As the IDN leadership team wrapped up 2019 RFA cycle workforce awards and dollars in June, 2020 there have been no new expenditures through the WF program in July-December, 2020. Final expenditures across project areas that are closed effective 12/31/20 are reflected in the wrap up budgets in the PPI section of this report. ***See below for previous WF awards that conclude in the last SAR period***.

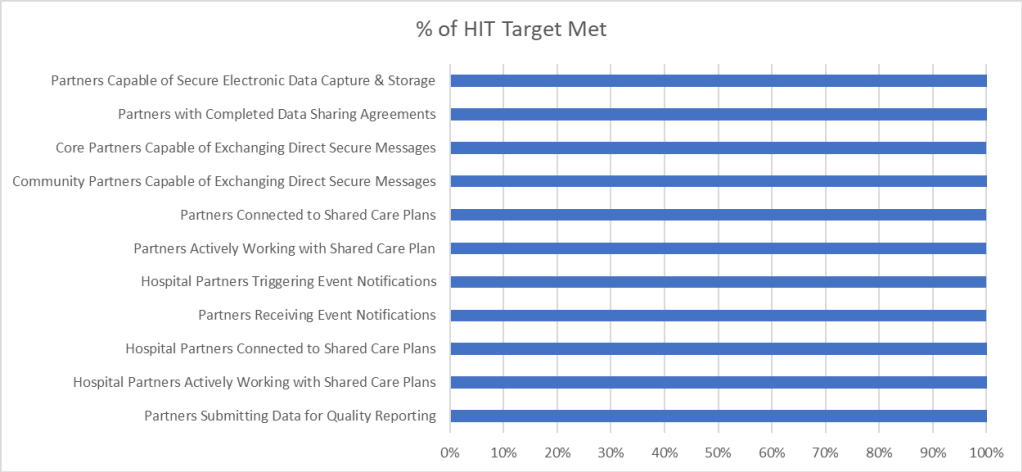
REDACTED TABLE

Project A2: IDN Health Information Technology (HIT) To Support Integration

Narrative

As reported in earlier periods, Region 1 IDN has met all health information technology (HIT) targets set forth in the original project plan.

Figure 1: Region 1 IDN - HIT Accomplishments Relative to Project Plan Targets



In the period July 1 – December 31 2020, Region 1 IDN Partners have sustained their use of HIT to support their integration projects. The COVID-19 response continued to disrupt care delivery for the entirety of the reporting period yet Partners were able to maintain their programs and the HIT systems that support care integration. In August 2020 the Massachusetts eHealth Collaborative Quality Data Service (MAeHC QRS) closed operations. Region 1 IDN Partners continued to provide data for quarterly reporting without the services of the data aggregation service.

Region 1 Partners were re-introduced to the UniteUs Closed Loop Referral Platform in November and December with the announcement that DHHS would support the system centrally. At the writing of this report, 11 organizations from our region have begun using UniteUs with an additional 30 organizations engaging with DHHS and the UniteUs vendor to learn more about the platform. The following paragraphs detail progress with our participating Partners.

Alice Peck Day

Organization	Electronic Data Capture & Secured Data Storage	Capable of Direct Secure Messaging	Data Sharing Agreement	Connected to Shared Care Plan	Actively Using Shared Care Plan	Receiving Event Notifications	Submitting Quality Data	Sending ADT Messages to ENS	Connected to Pre-Manage ED	Actively Using Pre-Manage ED
Alice Peck Day										

The Alice Peck Day (APD) team has met all Region 1 IDN goals. Activity in July 1 – December 31 2020 includes:

- Quality reporting: The team completed all data submissions for Jan-Jun 2020 measures (via the MAeHC QRS data aggregation platform). With the closure of the MAeHC QRS, the team continued to submit quality reporting data for the calendar quarter 3 and quarter 4 reports.
- Shared Care Planning / Event Notification: The team continued to support care integration activity with the Collective Medical Technology (CMT) platform. The hospital sent Admit Discharge and Transfer messages to CMT. The hospital emergency department received ED alerts. The team received notifications of emergency department and hospitalization events from CMT. The team supported multi-disciplinary care team (MDCT) shared care planning (SCP) within the CMT platform.
- Telehealth: The team continued its use of telehealth capabilities in a hybrid model with both in person and virtual visits.

Cheshire Medical Center

Organization	Electronic Data Capture & Secured Data Storage	Capable of Direct Secure Messaging	Data Sharing Agreement	Connected to Shared Care Plan	Actively Using Shared Care Plan	Receiving Event Notifications	Submitting Quality Data	Sending ADT Messages to ENS	Connected to Pre-Manage ED	Actively Using Pre-Manage ED
Cheshire Medical Center / DH Clinic Keene										

The Cheshire Medical Center (CMC) team has met all Region 1 IDN goals. Activity in July 1 – December 31 2020 includes:

- Quality reporting: The team completed all data submissions for Jan-Jun 2020 measures (via the MAeHC QRS data aggregation platform). With the closure of the MAeHC QRS, the team continued to submit quality reporting data for the calendar quarter 3 and quarter 4 reports.
- Shared Care Planning / Event Notification: The team continued to support care integration activity with the CMT platform. The hospital sent Admit Discharge and Transfer messages to CMT. The hospital emergency department received ED alerts. The team received notifications of emergency department and hospitalization events from CMT. The team supported multi-disciplinary care team (MDCT) shared care planning (SCP) within the CMT platform.
- Telehealth: The team continued its use of telehealth capabilities in a hybrid model with both in person and virtual visits.

Counseling Associates

Organization	Electronic Data Capture & Secured Data Storage	Capable of Direct Secure Messaging	Data Sharing Agreement	Connected to Shared Care Plan	Actively Using Shared Care Plan	Receiving Event Notifications	Submitting Quality Data
Counseling Associates							

The Counseling Associates team has met all Region 1 IDN goals. Activity in July 1 – December 31 2020 includes:

- Quality reporting: The team completed all data submissions for Jan-Jun 2020 measures (via the MAeHC QRS data aggregation platform). With the closure of the MAeHC QRS, the team continued to submit quality reporting data for the calendar quarter 3 and quarter 4 reports.
- Shared Care Planning / Event Notification: The team continued to support care integration activity with the CMT platform. The team received notifications of emergency department and hospitalization events from CMT. The team supported MDCT shared care planning (SCP) within the CMT platform.
- Telehealth: The team continued its use of telehealth capabilities in a hybrid model with both in person and virtual visits.

Dartmouth Hitchcock (Heater Road Clinic, General Internal Medicine, Department of Psychiatry, Mothers in Recovery, Pediatrics)

Organization	Electronic Data Capture & Secured Data Storage	Capable of Direct Secure Messaging	Data Sharing Agreement	Connected to Shared Care Plan	Actively Using Shared Care Plan	Receiving Event Notifications	Submitting Quality Data	Sending ADT Messages to ENS	Connected to Pre-Manage ED	Actively Using Pre-Manage ED
Dartmouth-Hitchcock Heater Road										
Dartmouth -Hitchcock GIM										
Dartmouth-Hitchcock Psychiatry										

The Dartmouth Hitchcock (D-H) teams have met all Region 1 IDN goals. As Dartmouth Hitchcock systemizes many of the learnings of the NH 1115 Waiver, the individual projects among Heater Road Clinic, General Internal Medicine, Department of Psychiatry, Mothers in Recovery, and Pediatrics are working more closely together for purposes of health information technology and quality data. Activity in July 1 – December 31 2020 includes:

- Quality reporting: The team completed all data submissions for Jan-Jun 2020 measures (via the MAeHC QRS data aggregation platform). The team completed chart abstractions for the CARE03 Diabetes and Hypertension measures. With the closure of the MAeHC QRS, the team continued to submit quality reporting data for the calendar quarter 3 and quarter 4 reports.
- Shared Care Planning / Event Notification: The team continued to support care integration activity with the CMT platform. The hospital sent Admit Discharge and Transfer messages to CMT. The hospital emergency department received ED alerts. The team received notifications of emergency department and hospitalization events from CMT. The team supported MDCT shared care planning (SCP) within the CMT platform. The Pediatric team continued expansion of its CMT attribution in order to receive event notifications for high risk and rising risk children and adolescents. The Mother's in Recovery program continued its use of CMT. Dartmouth Hitchcock continued its centralized and automated the patient enrollment process for all D-H clinics.
- Telehealth: The team continued its use of telehealth capabilities in a hybrid model with both in person and virtual visits.

Monadnock Community Hospital (Jaffrey and Ringe Practices)

Organization	Electronic Data Capture & Secured Data Storage	Capable of Direct Secure Messaging	Data Sharing Agreement	Connected to Shared Care Plan	Actively Using Shared Care Plan	Receiving Event Notifications	Submitting Quality Data	Sending ADT Messages to ENS	Connected to Pre-Manage ED	Actively Using Pre-Manage ED
Monadnock Community Hospital										

The Monadnock Community Hospital (MCH) Jaffrey and Ringe practices teams have met all Region 1 IDN goals. As mentioned in earlier reports, COVID-19 severely interrupted IDN activity with MCH including the deployment of the CMT event notification service with the hospital. MCH was not anticipated in Region 1 IDN goals for event notification and will not be implemented as the waiver period closes. Activity in July 1 – December 31 2020 includes:

- Quality reporting: The team completed all data submissions for Jan-Jun 2020 measures (via the MAeHC QRS data aggregation platform). The team completed chart abstractions for the CARE03 Diabetes and Hypertension measures. With the closure of the MAeHC QRS, the team continued to submit quality reporting data for the calendar quarter 3 report.
- Shared Care Planning / Event Notification: The team continued to support care integration activity with the CMT platform. The team was set up to receive notifications of emergency department and hospitalization events from CMT. The team supported MDCT shared care planning (SCP) within the CMT platform.
- Telehealth: The team continued its use of telehealth capabilities in a hybrid model with both in person and virtual visits.

Monadnock Family Services

Organization	Electronic Data Capture & Secured Data Storage	Capable of Direct Secure Messaging	Data Sharing Agreement	Connected to Shared Care Plan	Actively Using Shared Care Plan	Receiving Event Notifications	Submitting Quality Data
Monadnock Family Services							

The Monadnock Family Services (MFS) team has met all Region 1 IDN goals. Activity in July 1 – December 31 2020 includes:

- Quality reporting: The team completed all data submissions for Jan-Jun 2020 measures (via the MAeHC QRS data aggregation platform). With the closure of the MAeHC QRS, the team continued to submit quality reporting data for the calendar quarter 3 and quarter 4 reports.
- Shared Care Planning / Event Notification: The team continued to support care integration activity with the CMT platform. The team received notifications of emergency department and hospitalization events from CMT. The team supported MDCT shared care planning (SCP) within the CMT platform.
- Telehealth: The team continued its use of telehealth capabilities in a hybrid model with both in person and virtual visits.

New London Hospital – Newport Health Center

Organization	Electronic Data Capture & Secured Data Storage	Capable of Direct Secure Messaging	Data Sharing Agreement	Connected to Shared Care Plan	Actively Using Shared Care Plan	Receiving Event Notifications	Submitting Quality Data	Sending ADT Messages to ENS	Connected to Pre-Manage ED	Actively Using Pre-Manage ED
New London Hospital / Newport Health Center Practice										

The New London Hospital (NLH) Newport Health Center (NHC) team has met all Region 1 IDN goals. NLH completed its conversion to the Epic EHR in this reporting period. They also began sending admit-discharge-transfer messages to CMT for use in event notification. With the engagement of NLH in event notification, Region 1 exceeded its goal for hospital participation with CMT. Activity in July 1 – December 31 2020 includes:

- Quality reporting: The team completed all data submissions for Jan-Jun 2020 measures (via the MAeHC QRS data aggregation platform). The team completed chart abstractions for the CARE03 Diabetes and Hypertension measures. With the closure of the MAeHC QRS, the team continued to submit quality reporting data for the calendar quarter 3 and quarter 4 reports.
- Shared Care Planning / Event Notification: The team continued to support care integration activity with the CMT platform. The team received notifications of emergency department and hospitalization events from CMT. The team supported MDCT shared care planning (SCP) within the CMT platform.
- Telehealth: The team continued its use of telehealth capabilities in a hybrid model with both in person and virtual visits.

Valley Regional Hospital

Organization	Electronic Data Capture & Secured Data Storage	Capable of Direct Secure Messaging	Data Sharing Agreement	Connected to Shared Care Plan	Actively Using Shared Care Plan	Receiving Event Notifications	Submitting Quality Data	Sending ADT Messages to ENS	Connected to Pre-Manage ED	Actively Using Pre-Manage ED
Valley Regional Hospital										

The Valley Regional Hospital team has met all Region 1 IDN goals. Activity in July 1 – December 31 2020 includes:

- Quality reporting: The team completed all data submissions for Jan-Jun 2020 measures (via the MAeHC QRS data aggregation platform). The team completed chart abstractions for the CARE03 Diabetes and Hypertension measures. With the closure of the MAeHC QRS, the team continued to submit quality reporting data for the calendar quarter 3 and quarter 4 reports.

- Shared Care Planning / Event Notification: The team continued to support care integration activity with the CMT platform. The hospital sent Admit Discharge and Transfer messages to CMT. The hospital emergency department received ED alerts. The team received notifications of emergency department and hospitalization events from CMT. The team supported MDCT shared care planning (SCP) within the CMT platform.

- Telehealth: The team continued its use of telehealth capabilities in a hybrid model with both in person and virtual visits.

West Central Behavioral Health

Organization	Electronic Data Capture & Secured Data Storage	Capable of Direct Secure Messaging	Data Sharing Agreement	Connected to Shared Care Plan	Actively Using Shared Care Plan	Receiving Event Notifications	Submitting Quality Data
West Central Behavioral Health							

The West Central Behavioral Health (WCBH) team has met all Region 1 IDN goals. Activity in July 1 – December 31 2020 includes:

- Quality reporting: The team completed all data submissions for Jan-Jun 2020 measures (via the MAeHC QRS data aggregation platform). With the closure of the MAeHC QRS, the team continued to submit quality reporting data for the calendar quarter 3 and quarter 4 reports.
- Shared Care Planning / Event Notification: The team continued to support care integration activity with the CMT platform. The team received notifications of emergency department and hospitalization events from CMT. The team supported MDCT shared care planning (SCP) within the CMT platform.

- Telehealth: The team continued its use of telehealth capabilities in a hybrid model with both in person and virtual visits.

Other IDN-1 Partners (Not Coordinated Care or Integrated Care Partners)

Several Organizations in Region 1 have engaged with DHHS and the UniteUs closed loop referral platform. 11 of these organizations have already gone live on the system including:

- Better Life Partners
- Cheshire County - Drug Court
- Counseling Associates
- Doorway at Cheshire Medical Center
- Doorway at Dartmouth Hitchcock Medical Center
- Good Neighbor Health Clinic/Red Logan Dental Clinic
- Grafton County - Alternative Sentencing
- Keene Serenity Center
- NAMI New Hampshire
- Reality Check
- Sullivan County Department of Corrections

An additional 33 organizations from the region are at some stage of engaging with DHHS and UniteUs.

Several IDN-1 Partners are now actively using the CMT event notification service. These include:

- Crotched Mountain Community Care
- Home Healthcare Hospice and Community Services

- Lake Sunapee Region VNA and Hospice

Evaluation Project Targets

Region 1 IDN has met all HIT Performance Measure Targets.

Figure 2: Region 1 IDN HIT Performance Targets

Performance Measure Name	# of Participating Practices	Progress Toward Target				
		As of 12/31/18	As of 6/30/19	As of 12/31/19	As of 6/30/2020	As of 12/30/2020
Event Notification Services	11	5	8	11	11	11
Shared Care Plan	11	5	7	11	11	11
Closed Loop Referral	11	10	11	11	11	11
Data Reporting	11	11	12	12	12	12**
Data Sharing	11*	16	16	16	16	16
Care Coordination	11*	4	6	11	11	11

**Data sharing and Care Coordination were not performance measures in IDN1 original plan and did not have targets established. Assume 11 to align with other measures. Assume "Data Sharing" is referring to those with Data Sharing Agreement in place. Assume "Care Coordination" is those Partners actively using shared care plans.*

***Data reporting continued with 12 Partners even though the MAeHC QRS closed in August 2020.*

Budget

Region 1 IDN is projected to complete the program with $1.76M in health information technology expenses. This is 13% under our original budget of 2,032,250. The Region 1 IDN Health Information Technology program and expenditures supported the following accomplishments:

Provided technical support and training region wide so that all Region 1 IDN Integrated and Coordinated Care partners have the basic tools for Electronic Data Capture, Secure Data Storage, and Direct Secure Messaging.

Executed data sharing agreements and accompanying privacy training region wide so that Partners can lawfully exchange protected health information for purposes of care coordination and quality reporting.

Implemented a data sharing platform (Collective Medical Technologies) region wide so that Partners can receive real-time notifications of their patients' emergency department and hospital admissions, discharges, and transfers -and- so that Partners can create and securely access Shared Care Plans to support Multi-Disciplinary Core Teams.

Implemented a clinical quality data aggregation and reporting platform (Massachusetts eHealth Collaborative (MAeHC) – Quality Reporting Service) region wide so that Partners can submit clinical quality data (as opposed to just claims-based data), aggregate and match quality data at the IDN level, and report clinical quality for purposes of improvement, oversight, and value-based payment.

Figure 3: Region 1 IDN - HIT Budget as of Dec 31, 2020

Project to which budget is assigned	CY 2016 Actuals	CY 2017 Actuals	CY 2018 Actual	CY 2019 Actual	CY 2020 Actual	CY 2021 Projected	Total
Salary & Benefits	-	-	-	-	-	-	**-**
Technology	-	30,532	340,169	176,286	70,298	11,099	**628,384**
Sub-Contract	56,570	449,611	426,925	171,895	25,002		**1,130,003**
Occupancy							**-**
Travel							**-**
Total	**56,570**	**480,143**	**767,094**	**348,181**	**95,300**	**11,099**	**1,758,387**

The July - December 2020 reporting period included the following Technology expenditures:

- Quality Data Reporting: MAeHC provided quality data aggregation and reporting services to Partners through August of 2020 with the closure of MAeHC.
- Event Notification Service and Shared Care Plan: Collective Medical Technologies provided the Pre-Manage platform to our Partners throughout the reporting period. This program will be jointly sustained by Region 1 IDN and Dartmouth Hitchcock through the end of 2021.
- Website Support: The Region 1 IDN website (www.region1IDN.org) was transitioned from MAeHC to the Region 1 IDN Administrative team in March of 2020 and website support was transitioned to a new provider.

Project B1: Integrated Healthcare

Narrative

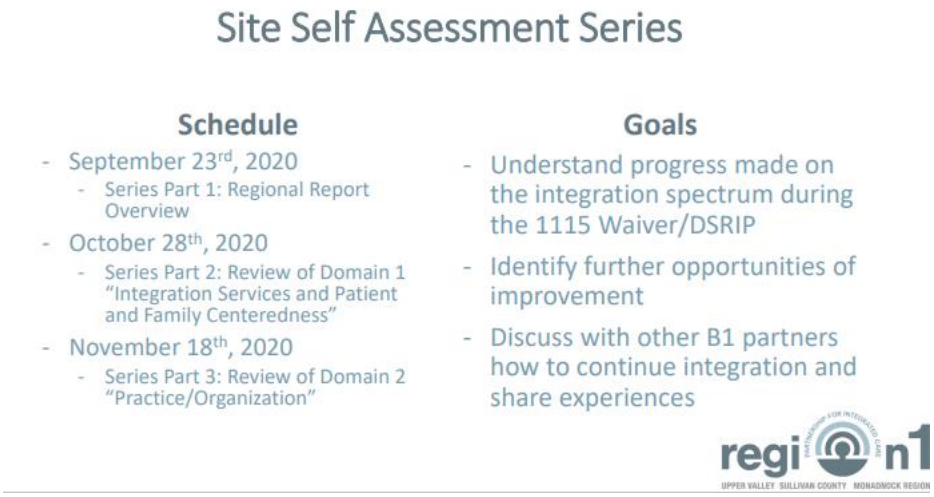
Include a detailed narrative which lists every participating provider at the practice **site** level and the progress made during the reporting period toward the Integrated Care Practice Designation. This should be **a detailed summary of where they are including what has been done, what has not yet been done**, the number of participating individuals, major accomplishments, barriers and setbacks.

Integrated Care Practice must include:

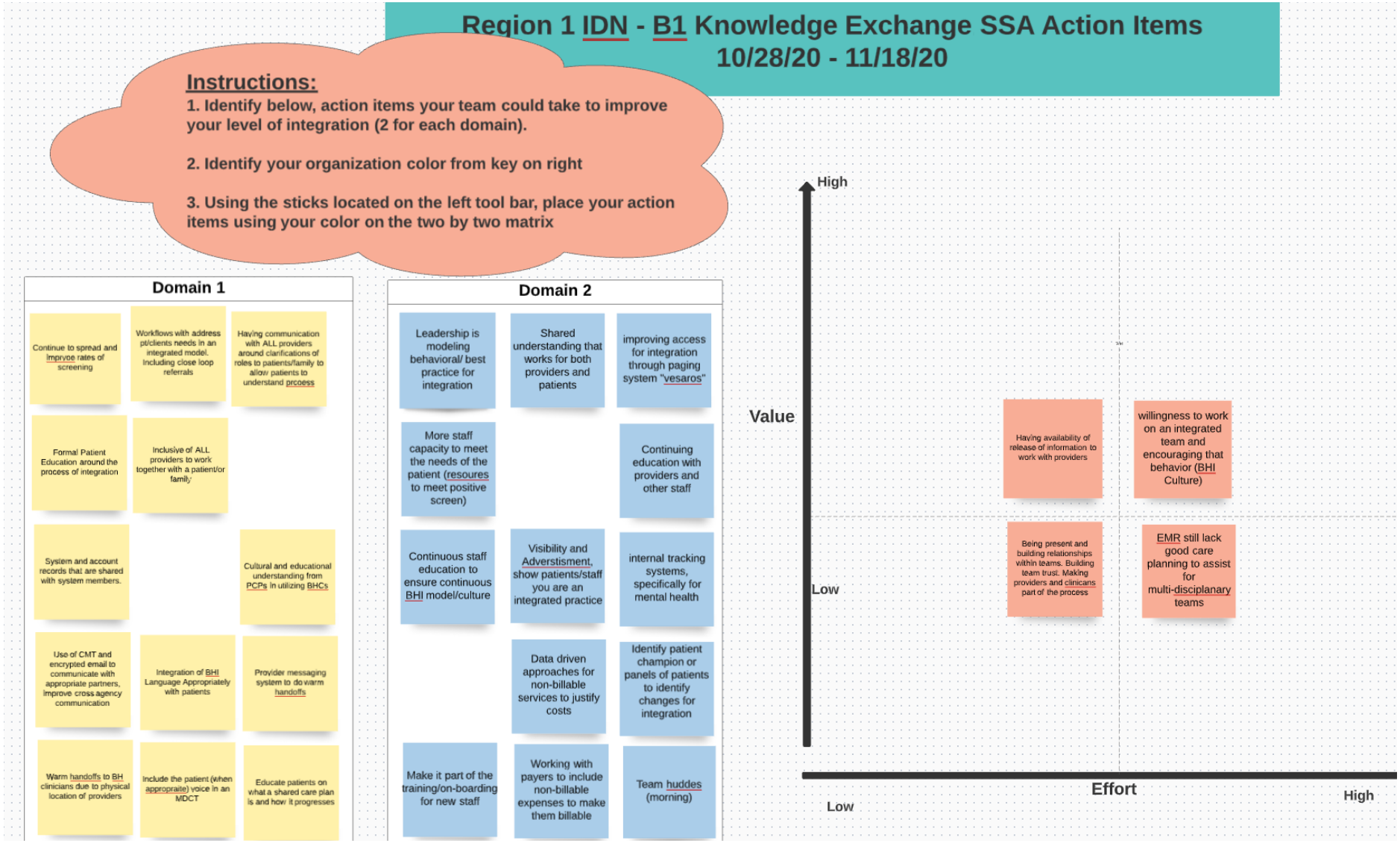
- Medication-assisted treatment (MAT)
- Evidence-based treatment of mild-to-moderate depression within the Integrated Practice setting either (e.g., IMPACT or other evidence-supported model)
- Enhanced use of technology

During the reporting period the IDN1 administrative team undertook a thorough financial review and composed a slate of funding scenarios for CY2021 to pitch to the Executive Committee (EC) for vote in early Fall, 2020. The EC voted to extend existing B1 contracts at the highest available rate depending on funds received in CY2020. Once this decision was made in October, 2020 the IDN leadership team began meetings with all B1 project staff and leadership to address the opportunity for continued project work in 2021 and project goals. All but one of the previously funded organizations, Monadnock Community Hospital, elected to move forward with IDN projects in the New Year. Given the significantly reduced rate of funding from previous years most projects will only be able to sustain hired positions with the funds but the teams appreciate the support and look forward to an additional year of project support around facilitating long term sustainability of project practices.

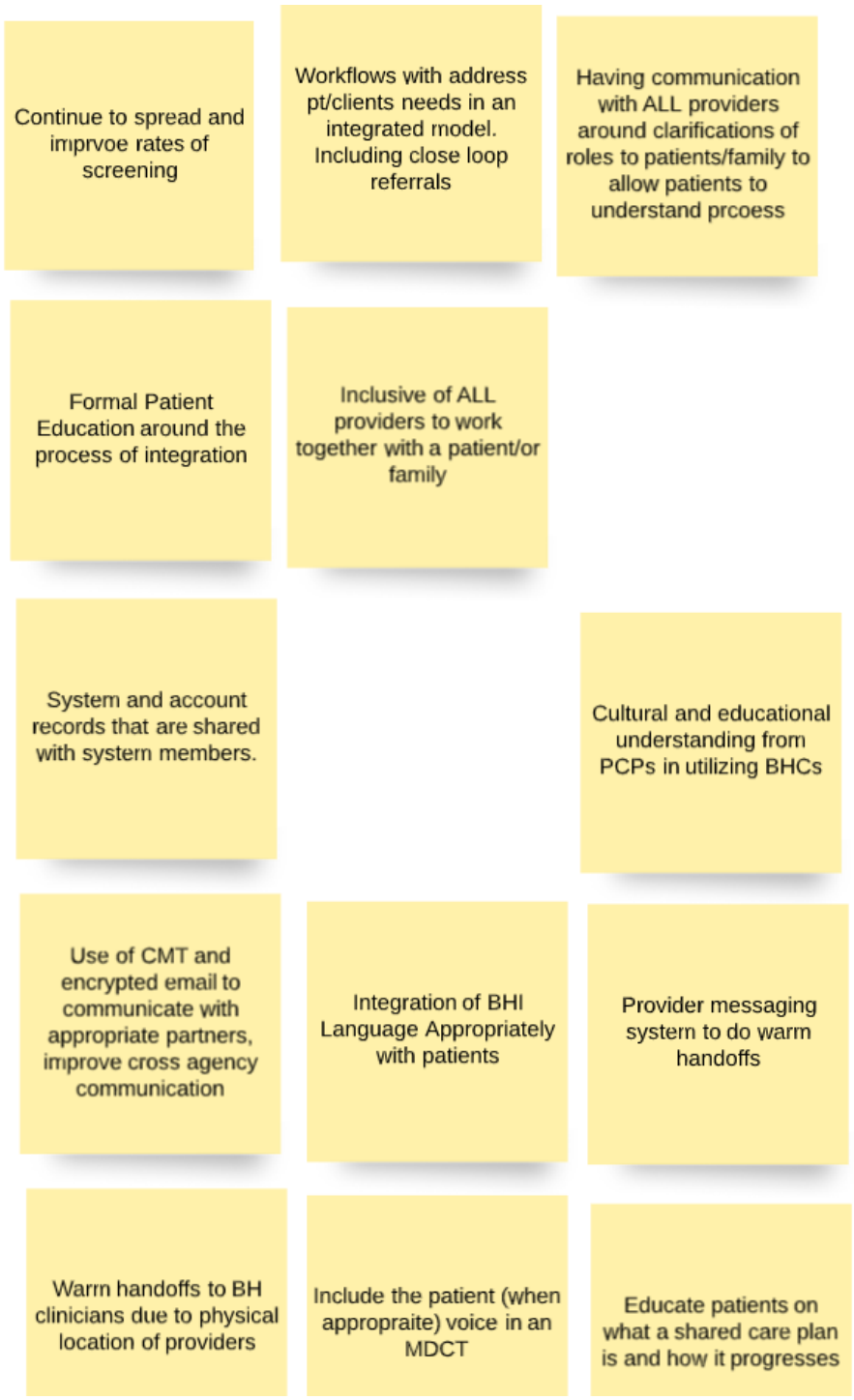
As a region, the B1 project teams participated in a once monthly Knowledge Exchange Series from September to November which focused on utilizing their Site Self-Assessment results. Below is the outline of the series. Throughout the series each meeting was dedicated to each domain, in which the teams discussed the questions and identified further opportunities to increase their scores. The IDN administration captured the brainstorming in Lucid Spark and provided each team a link to use the answers in a two-by-two matrix. A snapshot of this tool with the team's answers can be found below, with an example of the Dartmouth Hitchcock Pediatrics Team demonstrating the use of the tool.


Site Self Assessment Series
Schedule
- September 23rd, 2020
  - Series Part 1: Regional Report Overview
- October 28th, 2020
  - Series Part 2: Review of Domain 1 "Integration Services and Patient and Family Centeredness"
- November 18th, 2020
  - Series Part 3: Review of Domain 2 "Practice/Organization"
Goals
- Understand progress made on the integration spectrum during the 1115 Waiver/DSRIP
- Identify further opportunities of improvement
- Discuss with other B1 partners how to continue integration and share experiences
region1
UPPER VALLEY SULLIVAN COUNTY MONADNOCK REGION

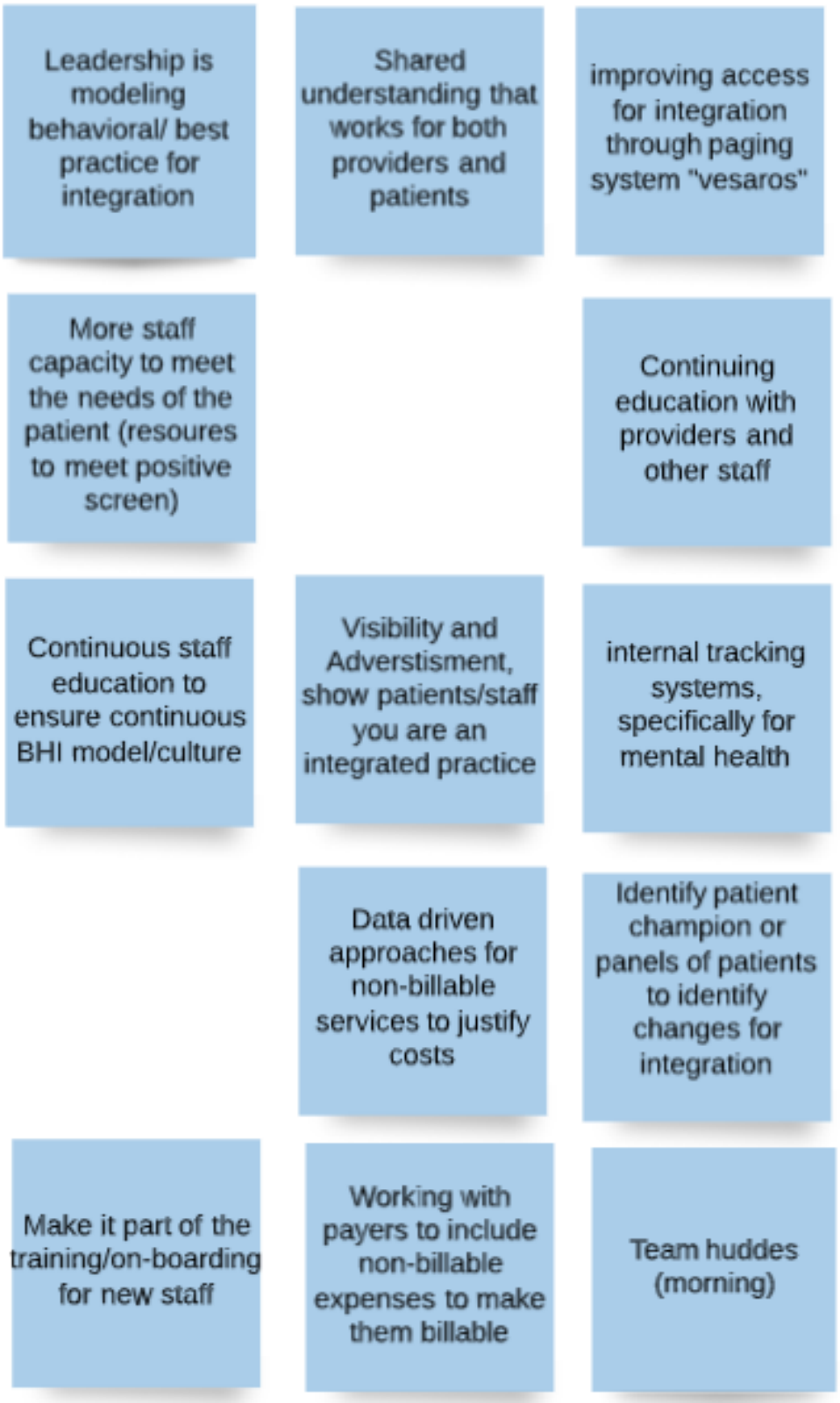
Overview of tool:



Answers for Domain 1:



Answers to Domain 2:


Leadership is modeling behavioral/ best practice for integration
Shared understanding that works for both providers and patients
improving access for integration through paging system "vesaros"
More staff capacity to meet the needs of the patient (resoures to meet positive screen)
Continuing education with providers and other staff
Continuous staff education to ensure continuous BHI model/culture
Visibility and Adverstisment, show patients/staff you are an integrated practice
internal tracking systems, specifically for mental health
Data driven approaches for non-billable services to justify costs
Identify patient champion or panels of patients to identify changes for integration
Make it part of the training/on-boarding for new staff
Working with payers to include non-billable expenses to make them billable
Team huddes (morning)

B1 Dartmouth-Hitchcock (DH) Heater Road, General Internal Medicine (GIM) and Pediatrics Project Updates

Project Overview

DH Heater Road was the pilot team for the region and the DH health system based in Lebanon that started to develop the work for many of the requirements. The system quickly on boarded the GIM department which operates in their own project space. In spring of 2019, the Pediatric department joined the work, quickly achieving Waiver milestones. The teams though operating in different departments and different cultures are working to align system approaches.

Current State: July 1, 2020 – December 31, 2020

Early in the reporting period, the DH team continued to move forward on improvement surrounding their established multidisciplinary care team meetings. They consistently met monthly through the month of October. Unfortunately, they lost their Care Team Coordinator (CTC) at the start of November due to the uncertainty surrounding financial sustainability of the position. While there were several discussions held on how to continue the success of their meetings without the CTC, they have not been able to adjust resources to continue the ongoing support of these meetings due to the continued resource constraints of Covid-19 response. There are ongoing conversations to continue the collaborative relationship with the local Community Mental Health Center. Additionally, with the team planning on continuing the B1 project work with the contract extension into CY2021, the team has decided to take a step back and reformat their process for MDCTs, to include their efforts with a chronic care MDCT that is occurring within the Heater Rd clinic. The team also experienced a setback when their provider champion left the Heater Rd practice in September. This has prevented the ongoing education to other providers on the value of the MDCT. The current team has drafted new goals for the contract extension year which includes, reformatting of the MDCT process, identifying a new provider champion, and improving synergy across the three participating departments.

During the reporting period, the Dartmouth Hitchcock Health (DH-H) system underwent a large update to the Comprehensive Core Standardized Assessment (CCSA). Representatives from multiple organizations under the DH-H system were part of the content creation including Alice Peck Day, New London Hospital and the Community Practice Groups. Now referred to as the "Adult Screener" (below) the implementation phase will begin in January of 2021 with education having started in the beginning of December. This screening update will affect our partners at Alice Peck Day, Newport Health Center/New London Hospital and Cheshire Medical Center. As part of the education, the revision team created a power point presentation (below).

CONFIDENCE

SOCIAL NEEDS

Q-ADULT SCREENER

For an upcoming appointment with **CAROLYN L KERRIGAN, MD** on 11/25/2020

*Indicates a required field.

Your provider and care team are interested in your own view of your health and things that may impact your health. We will ask you to complete this questionnaire once a year.

*How confident are you that you can control and manage most of your health problems?

Very Confident | Somewhat Confident | Not Very Confident | I do not have any health problems

We recognize that many things beyond medical care affect your health and wellbeing. We have care team members with special knowledge of assistance programs and community resources.

How hard is it for you to pay for the very basics like food, housing, medical care, and heating?

Not hard at all | Not very hard | Somewhat hard | Hard | Very hard | Decline

Within the past 12 months, you worried that your food would run out before you got money to buy more.

Never true | Sometimes true | Often true | Decline

Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.

Never true | Sometimes true | Often true | Decline

In the last 12 months, was there a time when you were not able to pay the mortgage or rent on time?

Yes | No | Decline

In the last 12 months, how many places have you lived?

In the last 12 months, was there a time when you did not have a steady place to sleep or slept in a shelter (including now)?

Yes | No | Decline

How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?

Never | Rarely | Sometimes | Often | Always

The next questions are about how you feel about different aspects of your life. For each one indicate how often you feel that way.

How often do you feel that you lack companionship?

Hardly ever | Some of the time | Often

How often do you feel left out?

Hardly ever | Some of the time | Often

How often do you feel isolated from others?

Hardly ever | Some of the time | Often

SOCIAL NEEDS (cont'd)

In the past 12 months, has lack of transportation kept you from medical appointments or from getting medications?

No | Yes | Decline

In the past 12 months, has lack of transportation kept you from meetings, work, or getting things needed for daily living?

No | Yes | Decline

Worked for pay | Attended school | Household duties | Unemployed | Permanently unable to work | Other | Retired

What was your main activity during most of the last 12 months?

Worked for pay | Attended school | Household duties | Unemployed | Permanently unable to work | Other | Retired

Do you have any legal issues that you are having difficulty resolving, such as disability, custody, parole, eviction, restraining orders, or other?

Yes | No

Do you feel unsafe in your relationships at home, school or work?

Yes | No | Prefer not to answer

Has someone threatened to hurt you, your family or your pets?

Yes | No | Prefer not to answer

Have you ever felt that someone wants to hurt you?

Yes | No | Prefer not to answer

Does anyone try to keep you from having contact with others or doing things outside your home?

Yes | No | Prefer not to answer

If any Social Need is POSITIVE:

Your responses to the last group of items indicate that you may have needs that we can help with. We have care team members with special knowledge of assistance programs and community resources. Help is free and confidential. What kind of help would you like? (Select one)

I do not need help | I already have help | I would like information about help | I would like help

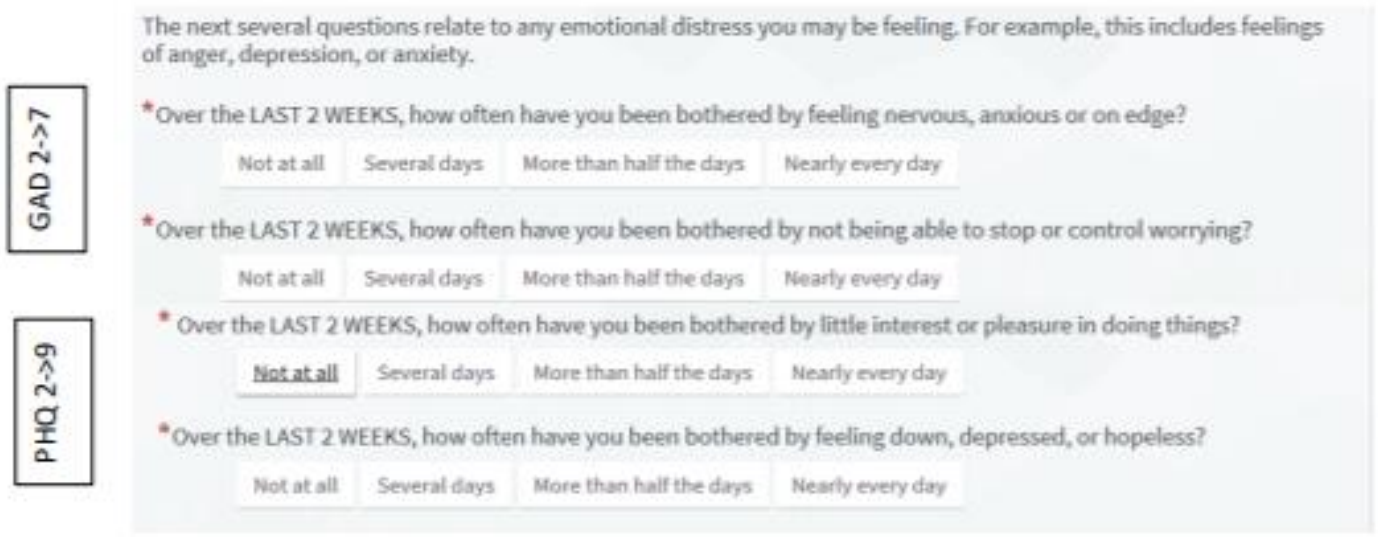
Should you wish help in the future, please let a member of your care team know.

OR:

Your responses to the last group of items indicate that you may have needs that we can help with. We have care team members with special knowledge of assistance programs and community resources. Help is free and confidential. What kind of help would you like? (Select one)

I do not need help | I already have help | I would like information about help | I would like help

One of our team members will reach out to you shortly.


GAD 2->7
PHQ 2->9
The next several questions relate to any emotional distress you may be feeling. For example, this includes feelings of anger, depression, or anxiety.
*Over the LAST 2 WEEKS, how often have you been bothered by feeling nervous, anxious or on edge?
Not at all
Several days
More than half the days
Nearly every day
*Over the LAST 2 WEEKS, how often have you been bothered by not being able to stop or control worrying?
Not at all
Several days
More than half the days
Nearly every day
* Over the LAST 2 WEEKS, how often have you been bothered by little interest or pleasure in doing things?
Not at all
Several days
More than half the days
Nearly every day
*Over the LAST 2 WEEKS, how often have you been bothered by feeling down, depressed, or hopeless?
Not at all
Several days
More than half the days
Nearly every day

AUD/SUD

*How often did you have a drink containing alcohol in the past year? Consider a 'drink' to be a can or bottle of beer, a glass of wine, a wine cooler, or one cocktail or a shot of hard liquor (like scotch, gin, or vodka).

Never | Monthly or less | 2 to 4 times a month | 2 to 3 times a week | 4 or more times a week

*How many drinks containing alcohol did you have on a typical day when you were drinking in the past year?

0 drinks | 1 to 2 drinks | 3 to 4 drinks | 5 to 6 drinks | 7 to 9 drinks | 10 or more drinks

*How often did you have four or more drinks on one occasion in the past year?

Never | Less than monthly | Monthly | Weekly | Daily or almost daily

*How often during the last year have you found that you were not able to stop drinking once you had started?

Never | Less than monthly | Monthly | Weekly | Daily or almost daily

*How often during the last year have you failed to do what was normally expected of you because of drinking?

Never | Less than monthly | Monthly | Weekly | Daily or almost daily

*How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?

Never | Less than monthly | Monthly | Weekly | Daily or almost daily

*How often during the last year have you had a feeling of guilt or remorse after drinking?

Never | Less than monthly | Monthly | Weekly | Daily or almost daily

*How often during the last year have you been unable to remember what happened the night before because of your drinking?

Never | Less than monthly | Monthly | Weekly | Daily or almost daily

*Have you or someone else been injured because of your drinking?

No | Yes, but not in the last year | Yes, during the last year

*Has a relative or friend or doctor or other health worker been concerned about your drinking or suggested you cut down?

No | Yes, but not in the last year | Yes, during the last year

*In the past year have you used marijuana, an illegal drug or a prescription medication for non medical reasons?

No | Yes

*In the past year, have you used opioids (oxycodone, Vicodin, heroin, fentanyl, buprenorphine, methadone, etc) for non-medical reasons?

No | Yes

The following questions concern information about your potential involvement with non-medical use of drugs (excluding alcohol and tobacco) during the past 12 months. Carefully read each sentence and select the appropriate box.

*Have you used drugs other than those required for medical reasons?

Yes No

*Do you use more than one drug at a time?

Yes No

*Are you always able to stop using drugs when you want to?

Yes No

*Have you had "blackouts" or "flashbacks" as a result of drug use?

Yes No

*Do you ever feel bad about your drug use?

Yes No

*Does your spouse, significant other or parents ever complain about your involvement with drugs?

Yes No

*Have you ever neglected your family or missed work because of your use of drugs?

Yes No

*Have you engaged in illegal activities in order to obtain drug?

Yes No

*Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?

Yes No

*Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)?

Yes No

For 65 and older:

STEADI

I have fallen in the past year.

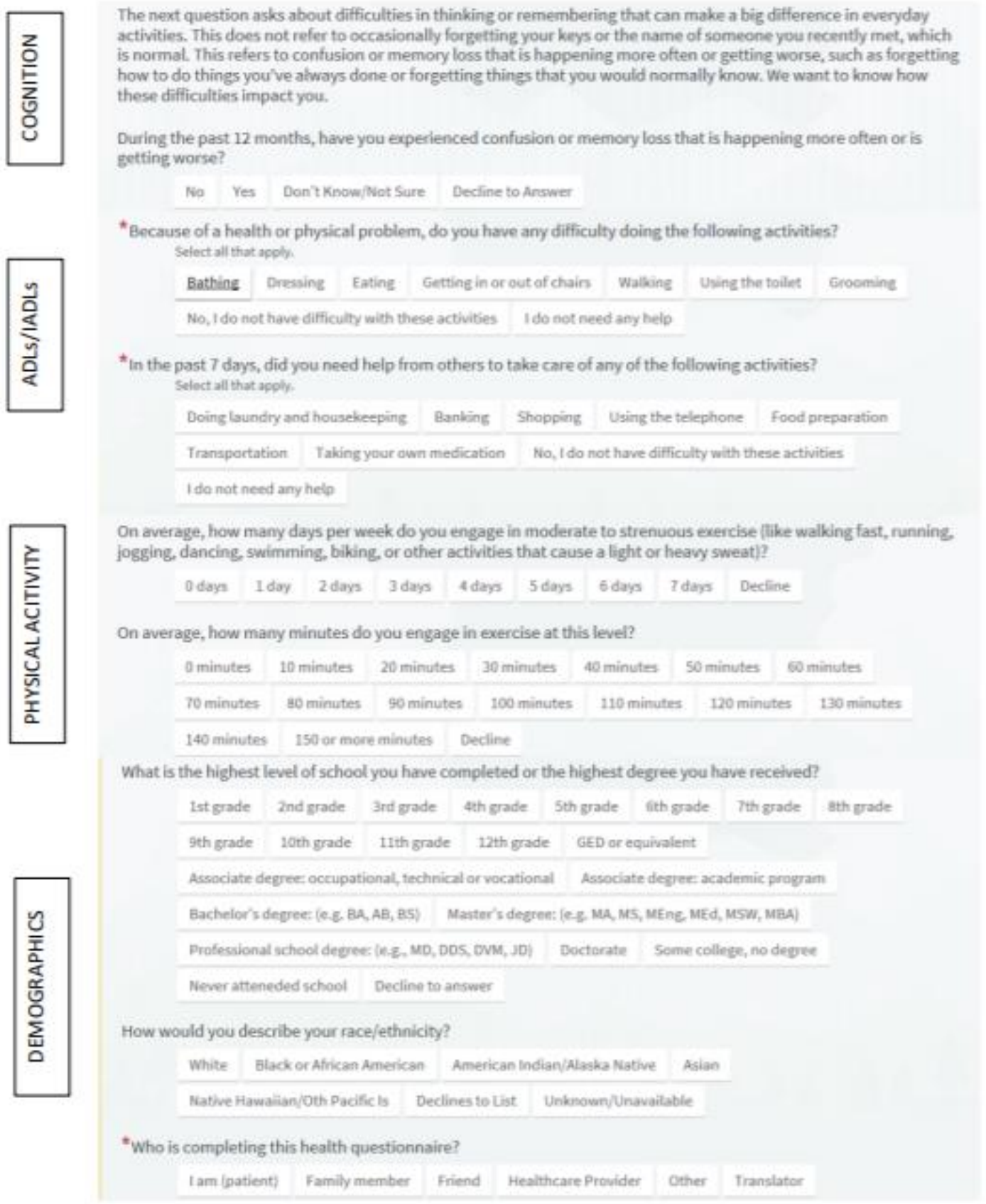
Yes No

Sometimes I feel unsteady when I am walking.

Yes No

I am worried about falling.

Yes No


COGNITION
The next question asks about difficulties in thinking or remembering that can make a big difference in everyday activities. This does not refer to occasionally forgetting your keys or the name of someone you recently met, which is normal. This refers to confusion or memory loss that is happening more often or getting worse, such as forgetting how to do things you've always done or forgetting things that you would normally know. We want to know how these difficulties impact you.
During the past 12 months, have you experienced confusion or memory loss that is happening more often or is getting worse?
No
Yes
Don't Know/Not Sure
Decline to Answer
ADLs/IADLs
*Because of a health or physical problem, do you have any difficulty doing the following activities?
Select all that apply.
Bathing
Dressing
Eating
Getting in or out of chairs
Walking
Using the toilet
Grooming
No, I do not have difficulty with these activities
I do not need any help
*In the past 7 days, did you need help from others to take care of any of the following activities?
Select all that apply.
Doing laundry and housekeeping
Banking
Shopping
Using the telephone
Food preparation
Transportation
Taking your own medication
No, I do not have difficulty with these activities
I do not need any help
PHYSICAL ACITIVITY
On average, how many days per week do you engage in moderate to strenuous exercise (like walking fast, running, jogging, dancing, swimming, biking, or other activities that cause a light or heavy sweat)?
0 days
1 day
2 days
3 days
4 days
5 days
6 days
7 days
Decline
On average, how many minutes do you engage in exercise at this level?
0 minutes
10 minutes
20 minutes
30 minutes
40 minutes
50 minutes
60 minutes
70 minutes
80 minutes
90 minutes
100 minutes
110 minutes
120 minutes
130 minutes
140 minutes
150 or more minutes
Decline
DEMOGRAPHICS
What is the highest level of school you have completed or the highest degree you have received?
1st grade
2nd grade
3rd grade
4th grade
5th grade
6th grade
7th grade
8th grade
9th grade
10th grade
11th grade
12th grade
GED or equivalent
Associate degree: occupational, technical or vocational
Associate degree: academic program
Bachelor's degree: (e.g. BA, AB, BS)
Master's degree: (e.g. MA, MS, MEng, MEd, MSW, MBA)
Professional school degree: (e.g., MD, DDS, DVM, JD)
Doctorate
Some college, no degree
Never atteneded school
Decline to answer
How would you describe your race/ethnicity?
White
Black or African American
American Indian/Alaska Native
Asian
Native Hawaiian/Oth Pacific Is
Declines to List
Unknown/Unavailable
*Who is completing this health questionnaire?
I am (patient)
Family member
Friend
Healthcare Provider
Other
Translator

Breast Cancer Risk Assessment for women:

An important part of your breast health plan is understanding your breast cancer risk factors. All women can begin talking to their medical provider about their personal risk factors as early as age 25.

Depending on medical and family history, women at average risk of breast cancer can begin breast cancer screening with mammograms as early as age 40. All women should receive regular mammograms by age 50.

Your answers to the questions below will help you and your provider decide when you should start screening for mammograms.

1. Have you had a breast biopsy and been told you have atypia or LCIS (Lobular Carcinoma in Situ)?

No Yes Unknown/Unsure

2. Do you have a 1st or 2nd degree relative on either side of the family with: male breast cancer, ovarian cancer, female breast cancer diagnosed before 50 years old, estrogen negative female breast cancer diagnosed before 60 years old? First or second degree relatives are: mother, father, sisters, brothers, aunts, uncles.

No Yes Unknown/Unsure

3. Have 3 or more people on the same side of your family all had breast or prostate cancer? Example: 3 uncles on your father's side with prostate cancer or 3 aunts on your mother's side with breast cancer.

No Yes Unknown/Unsure

4. Have you ever been tested for an increased risk of breast cancer (like BRCA 1 & 2)?

No Yes Unknown/Unsure

5. Were you ever diagnosed with breast cancer?

No Yes

6. Were you ever diagnosed with ovarian cancer?

No Yes

7. Did you have chest radiation between the ages of 10-30 years old?

No Yes

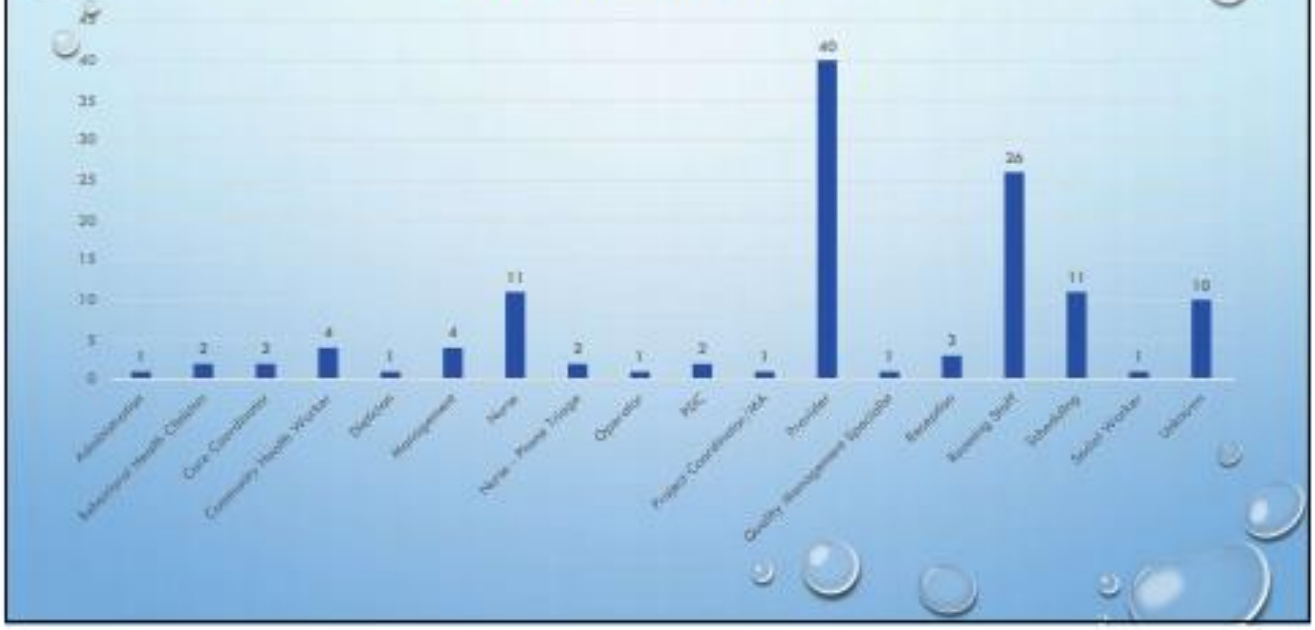
Results can be viewed in your note using several different .phrases that may contain some guidance. For example, the breast cancer risk assessment .phrase ".qbrcarisk" will return responses plus this guidance:

Instructions for Providers:
Patients answering YES to questions 1 or 7 should be referred to a comprehensive breast center for further evaluation. Patients with any other YES answer should be referred to a familial cancer screening program for consideration of genetic testing. Women with any positive response are not eligible for standard shared decision making for breast cancer screening in the primary care setting.

To document all responses from the Adult Screener, the .phrase is ".qadultscreener"
Under construction, additional .phrases for subsections of the Adult Screener.

LESSONS LEARNED FROM IMPLEMENTING THE CCSA & OTHER PATIENT QUESTIONNAIRES

WHO RESPONDED



WHICH PRACTICES RESPONDED?

- ALICE PECK DAY (12)
- BEDFORD (11)
- LEBANON GIM (10)
- LYME (7)
- HEATER RD (16)
- KEENE (1)
- MANCHESTER (21)
- NASHUA (8)
- PEDIATRICS (1)
- UNKNOWN (36)

AND NOW FOR THE SURVEY RESULTS

- IMPLEMENTED THE CCSA
  - YES 52%
  - NO 41%
  - UNKNOWN 7%
- RESPONSIBLE FOR ENSURING QUESTIONNAIRE COMPLETED
  - RECEPTION 34%
  - ROOMING STAFF 42%
  - PROVIDERS 5%
  - OTHER 19%
- CAN FIND RESULTS IN EDH
  - AGREE 73%
  - DISAGREE 27%
- UNDERSTAND MY ROLE IN POSITIVE SCREENS
  - AGREE 54%
  - DISAGREE 34%
  - N/A 11%

RESULTS CONTINUED

- SUFFICIENT RESOURCES
  - AGREE 55%
  - DISAGREE 38%
- ENOUGH IPADS
  - AGREE 53%
  - DISAGREE 22%
- ENCOURAGE USE OF MYDH
  - AGREE 95%
  - DISAGREE 5%
- WOULD LIKE ADDITIONAL TRAINING
  - AGREE 75%
  - DISAGREE 20%
- ADD REVIEW OF SYMPTOMS TO ADULT SCREENER
  - AGREE 57%
  - DISAGREE 31%

WHAT PROCESS WORKS WELL?

- PATIENTS COMPLETING THE QUESTIONNAIRE PRIOR TO APPT – EITHER IN WAITING AREA OR BY MYDH
- ROOMING STAFF CONFIRMING QUESTIONNAIRES COMPLETE BEFORE PROVIDER SEES PATIENT
- ROOMING STAFF NOTING AREAS OF CONCERN FOR PROVIDERS
- PRE-VISIT CALL REMINDING PATIENT TO COMPLETE QUESTIONNAIRE VIA MYDH OR TO ARRIVE 20 MIN EARLY AT APPT
- HAVING STAFF DESIGNATED TO SUPPORT PATIENTS (CHW, BHC, SOCIAL WORK, ETC.)

The DHMC Adult teams participate in the completion of the IDN evaluation activities including the "Evaluation Worksheet" and an A3 (below).

Goals

- What were your original goals and expectations for the project?
- Has your perception of the project changed over time and did your goals changed as a result?
- What goals were met/unmet (speak to goals that have progressed but have not fully been met)?
- Do you have new or additional goals in achieving further integration?
- Where/are your goals supported across your organization (clinicians, support staff, financial, management)?

1. Original goals/expectations: Create a new team, new set of tools and new set of processes that bridge the gap, both internally and with external partners, in integrating medical and mental health care. Additionally, it was our hope these new care pathways would become a part of a statewide system that would serve to transform integrated delivery of care combined with new billable revenue streams to sustain the work going forward.
2. Systems barriers such as privacy and consent regulations posed a significant barrier to the speed of implementation and scope of community partners who could be reasonably on boarded through the MDCT and SCP. We hoped certain system capacities such as CMT interfacing with different EHRs, would relieve the need for direct workforce involvement. This limitation in electronic communication necessitates on going personnel with significant time commitments available to them to continue the work as designed. Early in the project development, we expected a larger cohort of Medicaid patients identified through completion of the CCSA and that we would be able to expand our work from a focus on shared WCBH/DHMC patients to other external partners leveraging the progress made with the pilot practices across the Medicaid population. Goals changed to optimizing the efficiency of the MDCT for the smaller cohort of identified patients.
3. Goals Met:
4. Team- Large and cohesive team across multiple DHMC primary care units and our community mental health center, WCBH. The mutual appreciation of the clinical work performed by each organization has been greatly enhanced

and is cited as one of the primary benefits of this work which directly translates to better patient outcomes as teams are able to communicate effectively and in a timely manner.

5. Tools- We successfully created and effectively utilized shared care plans within the CMT platform.
6. Processes- We successfully implemented MDCT teams involving dozens of providers who met monthly over the past two years. Along the way solving problems related to technology, geography, clinic cultures, provider schedules, patient privacy and effective utilization of provider time with meaningful outcomes for patients.
7. Partners- Most solid partnership was with WCBH and DHMC primary care. We were able to routinely involve Pathways of the Upper Valley, made progress toward onboarding Headrest (barriers related to substance use privacy were the limiting for this partnership), and Counseling Associates of the Upper Valley (barrier related to patient identification and practice capacity were limiting for this partnership).
8. New Goals: Internal integration of mental health primary care within DHMC will continue. Ongoing external partnerships will be modified in the following ways: the effort to onboard external partners beyond WCBH will cease. The MDCT will be integrated with another interdisciplinary team within primary care. The frequency and depth of communication with WCBH will be scaled back with an effort to proactively identify Medicaid patients most at risk of dangerously fragmented care.
9. Goals Supported: Improving the integrated delivery of care for Medicaid patients remains a priority of both institutions. However, the continuation of further program development and maintenance of existing teams is unlikely without ongoing additional sources of revenue. Shifting existing workloads into the preexisting workforce creates an operational burden that's not sustainable.

A3 Lean Method

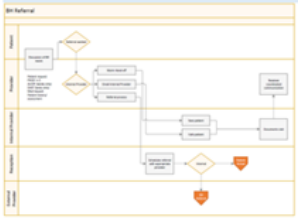
Project Title: IDN B1 MDCT DHMC Primary Care and West Central Behavioral Health (WCBH) Project **Date: 12/8/2020**

Team: Dan Moran, Matt Duncan, Chelsea Worthen, Sophie Tell, Laura Blodgett, Michelle Lin, Joanne Wagner, Cynthia Twombly

Project Background

WCBH and DHMC are the two largest providers of medical and mental health services in our area. Many patients receive services provided by both organizations. Currently there is no clear process for ensuring the safe and optimal transfer of information or coordination of vital services for patients between the two organizations. This lack of coordination increases the risk of patients not receiving needed services, dropping out of treatment, or receiving costly duplicative treatment or suboptimal coordination of services.

Current Conditions



SPECIFIC AIM STATEMENT: To improve the coordination of inter-organizational, patient-centered care for Medicaid patients with psychiatric diagnoses. This will be done through the co-creation and ongoing mutual support of an inter-organizational multi-disciplinary team (MDCT) led by a Medicaid Care Team Coordination (CTC).

Goals/Objectives

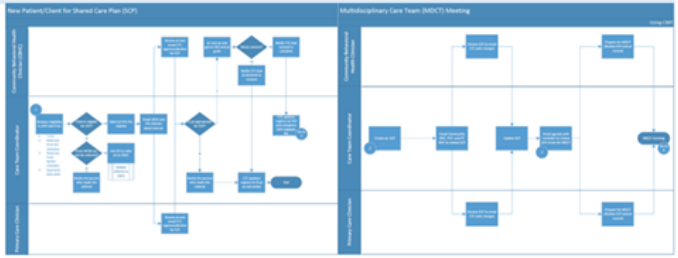
- Improve the coordination of inter-organizational, patient-centered care for Medicaid patients.
- Improve health outcomes for Medicaid patients.
- Improve patient access to appropriate services matched to patient needs and delivered in an appropriate timeframe.
- Improve the use of existing resources.
- Improve both patient and provider satisfaction in delivering coordinated care between the two provider organization.
- Gather relevant data to ensure process and outcomes measures are being met.
- Work to ensure that the new team and process are sustainable and scalable.

Analysis

- Privacy/information sharing between organizations is a complex issue and has hindered the ability of DHMC and WCBH to coordinate care for their shared patients. In order for the two providers to work collaboratively and have a shared care plan (SCP) for high-risk patients the consent process needed to be addressed.
- Identification of patients that may not be accessing primary care regularly is also a challenge. A CCSA has been put in place to regularly identify patients that need additional supports, but it has been difficult to find patients that are eligible for SCP/MDCT.

Plan the Improvement

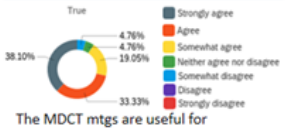
The co-creation and ongoing mutual support of an inter-organizational multi-disciplinary team (MDT) led by a Medicaid Care Team Coordination (CTC) will help to bridge this gap to improve the delivery of care to patients, improve patient and provider satisfaction in delivering this care and improve the utilization of the valuable resources of each organization and their community partners.



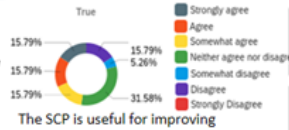
Do the Improvement

- Consent form developed
- Workflows developed
- Care Team Coordinator hired and trained
- Active across Heater Road and General Internal Medicine
- 26 Shared Care Plans
- MDCTs held monthly one for each department
- Ongoing work with DH Emergency Department
  - ED with X Unique Shared Care Plans

Check the Results



The MDCT mtgs are useful for improving communications between providers



The SCP is useful for improving communication between partners

Cohort	# of Patients	ED Visit Count (a)	(b) 6 Mos Pre-Engagement	(c) 6 Mos Post-Engagement	% Change
Lebanon	12		11	6	-45%

Cohort	# of Patients	Primary Care Visits No Show Rate (a)	(b) 6 Mos Pre-Engagement	(c) 6 Mos Post-Engagement	% Change
Lebanon	12		12%	6%	-50%

Act & Determine Next Steps

- Internal integration of mental health primary care within DHMC will continue.
- The MDCT will be integrated with another interdisciplinary team within primary care.
- The frequency and depth of communication with WCBH will be scaled back with an effort to proactively identify Medicaid patients most at risk of dangerously fragmented care.

Dartmouth Hitchcock- Pediatrics Practice Updates

Project Overview

The DH-Lebanon based pediatric team has been meeting regularly since the summer of 2019. Over the course of the past six months, the team has reviewed their process flow for the DART screen (which meets the CCSA requirements) and identified opportunities for improvement.

Current State: July 1, 2020 – December 31, 2020

During the reporting period, the team continued to work on improving their Multidisciplinary care team (MDCT) meetings. While the core pilot team continued to meet regularly twice a week on Wednesdays and Fridays, they began adding additional providers. They continue to work on building partnerships with external organizations to conduct MDCTs with as well. There are ongoing conversations with the two local behavioral health providers, however they have had greater progress with social support organizations. They have had monthly meetings which focus on collaborative care partnerships for the shared patient/client. The Dartmouth Hitchcock Pediatric team has from the start has been actively engaged with the event notification system within the Collective Medical platform. At the end of the calendar year, the team had approximately 600 patients they were managing in their "Mini MDCT" program which uses the event notification platform. During the reporting period, they expanded on their ability to manage these patients by enhancing their risk stratification structure shown below.

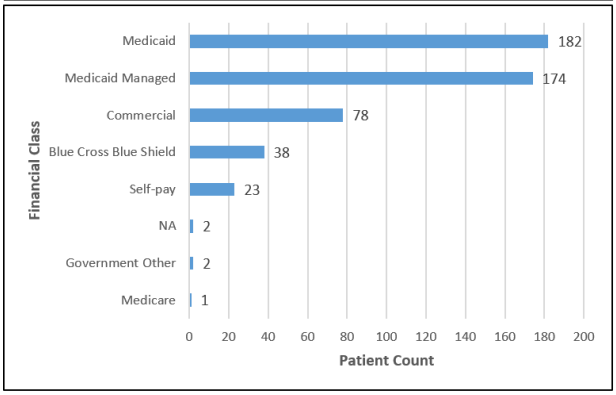
Risk Levels	Overview	Medical	Mental	Environmental	Social	Continuity	Follow-up needed (with PCP or other team
0 (Baseline)	Not on IDN List Routine care only no past or current needs	No or minor chronic medical conditions (ex: allergic rhinitis, acne)	Psycologically healthy	Stable Housing Reliable Transportation Safe living conditions access to food	Strong Support System family network friends at school	Attend 95% of lifetime WCC Appropriate use of health services	WCC only
1 (Minimal risk)	History of minor needs well connected with appropriate resources	Stable chronic medical conditions that require ongoing monitoring (such as well controlled asthma, or	PHQ 9A=5 GAD 7 = 5 Stable ADHD or R/O ADHD Future mental screening for younger children	previous housing instability previous food insecurity limited food access (dietary restrictions)	CPS hx stable placement/adopted 504/behavioral plan at school family stress (divorce, job	Overdue for WCC with no known risk factors; attended >90% lifetime WCC 1-2 ED/Urgent Care visits/year	May need visit or phone check in between WCC
2 (Moderate risk)	Major needs that all are currently being addressed minor unmet needs	Medical conditions that require frequent management or monitoring (ex: Diabetes), evaluation for IEP/504	PHQ 9A=10 GAD 7 = 10 +CRAFFT (age 17 and up) ODD Subs misuse poorly controlled ADHD	housing instability food insecurity reliant on Medicaid/public transportation financial stressors	CPS/Foster placement limited support system history of interpersonal violence abuse/neglect inactive insurance	Overdue for WCC with minor risk factors. More than two no-shows. Attended 65-90% lifetime WCC 3-4 ED/Urgent Care visits/year	Needs follow-up in 1-3 months
3 (High risk)	Major medical or psychosocial needs that are not fully addressed	Medical issues that are not fully addressed (ex: FTT, poorly controlled asthma) numerous medical issues and DME (ex: trach, VP shunt)	hospitalization or suicide attempt PHQ 9A=15 GAD 7= 15 PTSD + CRAFFT age 15/16 or other substance abuse Cooccuring diagnoses	homeless (including couch surfing) shortage of food no access to transportation geographic barriers economic concerns	No one to go to for help active CPS involvement potentail safety concerns truancy/absence from school JPPO involvement residential placement no insurance	Attends <65% lifetime WCC 4 or more no-shows 5 or more ED/Urgent Care visits/year	Needs follow-up in 2-4 weeks
4 (Highest risk)	Multiple or major issues that need attention immediately	Multiple high risk active concerns	Multiple high risk active concerns PHQ 9A= 20 GAD 7= 20 + CRAFFT age 12-14 Active suicidal ideation psychiatric hospitalization or suicide attempt in past 6mo	Multiple high risk active concerns acute homelessness	Multiple high risk active concerns abuse/neglect/DV no insurance	Unable to reach family or schedule appointment for major issues Lost to F/U > 2 years	Needs follow-up in 1-2 weeks consider report to CPS if unable to reach family

Later in the reporting period, the project team began focusing on sustainability or program needs after completion of the B1 2021 extension funding. To do this, they engaged the help of one of the Dartmouth Hitchcock data analysts which began looking into various data points such as no show rates, emergency

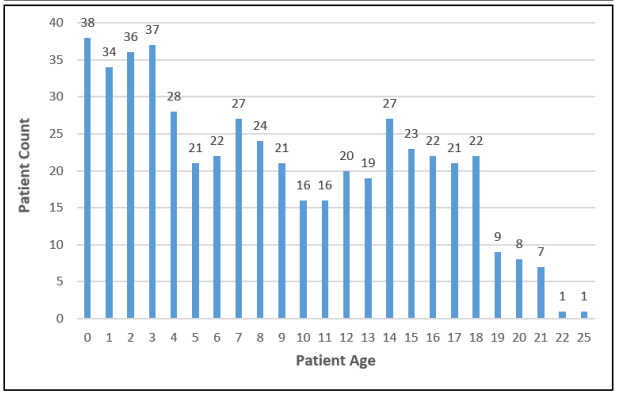
department visits, depression screening and more. The preliminary data is captured below, the project team reviewed these findings and adjusted based on their long term goals. The team plans to meet with the data analysis on a quarterly basis going forward.

Number of Patients in Program		**500**	
Patients in Program 6+ Months		**156**	
Primary Care Visits			
		Months from Referral	
	Patient Count	6 Months Pre	6 Months Post
# of Patients with 1 or more visits	156	146	131
% of Patients with 1 or more visits	156	94%	84%
Visit Count	156	685	573
Visits per Patient	156	4.4	3.7
Visit Count Range	156	0 - 24	0 - 26
No Show/Late Cancellation Rate	156	21.0%	20.9%

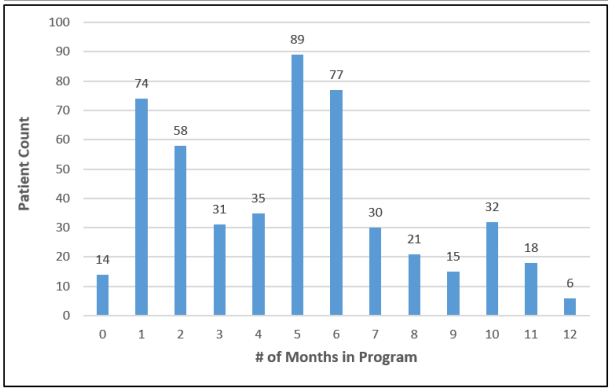
Financial Class (Primary)



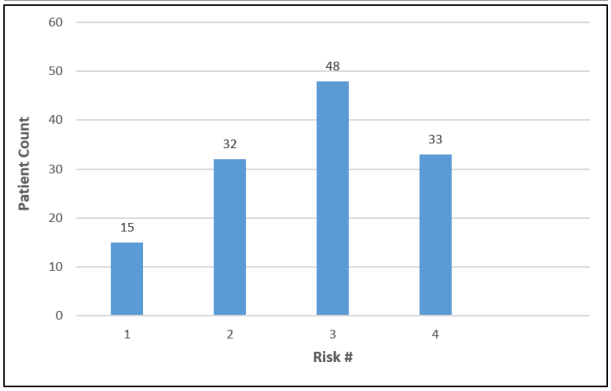
Age Distribution



Time in Program



Internal Risk #



Additionally, the project team participated in the reporting period evaluation activities completing both the "Evaluation Worksheet" and A3. The team met to debrief the worksheet, and discussed possible new

goals for the extended contract period and presented their A3 at the December IDN Knowledge Exchange. The final drafts of the worksheet evaluation and A3 are below.

Goals

10. What were your original goals and expectations for the project?
11. Has your perception of the project changed over time and did your goals change as a result?
12. What goals were met/unmet (speak to goals that have progressed but have not fully been met)?
13. Do you have new or additional goals in achieving further integration?
14. Where/are your goals supported across your organization (clinicians, support staff, financial, management)?

Initially, we hoped to use this collaboration to address the wider needs of our patient population. We had anticipated accomplishing this with family/patient involvement and more collaborative care efforts. The perception of the project has not changed, it is a matter of time and natural progression that will perpetuate continued success for continued support for families and staff.

Our overarching goals were to create an infrastructure and improve the approach for families at risk by:

1. Identify (and track) families at risk
2. Identify family goals and needs
3. Match goals/needs with resources
4. Support families to engage with resources

Collaboration through our MDCT is a strong point of our work and continuing these is a goal that we are constantly meeting. The goals that were essentially unmet but ongoing are outside collaboration with other organizations. We are currently on the cusp of having external MDCT meetings with the parties best suited to clinic needs.

Maintaining this collaborative effort remains one of our main goals for our clinic moving forward.

Providers are buying in to the value of our team and contributing more patients to our lists, which will become a problem without the sustainability in terms of financing future work; the support for our providers/patients will fall off come January 1, at a time when we anticipate that most providers will fully be utilizing the IDN team, which could lead to lapses in follow up if we do not have funding to continue.

Our clinicians and support staff seem supportive of our team as they learn more about what we can do. The team has created a strong foundation to help identify patients and teams in need of more services and attention.

IDN Project Components

15. Do you feel you successfully implemented and improved these component?
    1. Is there further implementation/improvement to do?

16. What barriers made it difficult to achieve or fully implement this component? What barriers will prevent sustainability (financial, leadership support, culture, staff, relationships, resources, other)?
17. Was implementing this component valuable to how you care for patients and why?
18. Did implementing this component enhance your professional satisfaction and relationships with coworkers, why?
19. Are there adjustments needed to make this component more valuable? Could these components be synchronized with other organization initiatives?
20. Are there materials missing or needing to be updated to complete the implementation (e.g., process flows, protocols, etc.)?

CCSA	-
MDCT	Yes, internally and with family resource centers; the hope is that building this robust interactions will bring more value to our team's work to other community organizations to then also allow mental health groups to join into these meetings. COVID is a big barrier in this regard. I think this is immensely valuable to patient care because it allows us to keep close tabs on high risk patients and brainstorm together to problem solve situations that we would otherwise just overthink. I think these meetings enhanced my professional satisfaction because it provides a setting where we can all problem solve together and come up with the best solutions possible for us in that moment in time. I think I would find even more value if we could meet with all of the providers in clinic so they could see what happens and how these meetings are valuable. We are constantly improving our process flow, so I don't see a significant need to change anything for complete implementation. Some barriers we faced even pre-covid was outside organizations capacity to be able to support extra patient meetings. Our team did however act appropriately and utilized the available resources to hold collaborative meetings and assist with identifying the patients in need.
SCP	Partially - We have integrated this structure into our tracking and eventually may use in eDH or CMT. It is a helpful format for discussion and will see in the future about using it as a tool for asynchronous communication. This is another area for improvement but the potential is there once we successfully have families wanting this type of service.
Integration Workflow	Partially – we have a number of workflows that we have developed and will continue to refine over time.

Project Process

21. What went well?
22. Were there project or change management pieces missing which would have better supported meeting the goals?
23. Is there anything you would have done differently?

Project Planning	It would have been much better to be a part of this project from the outset as we really didn't have sufficient time to plan before being asked for outputs.
Project Implementation	Our initial focus was on replicating what was done at other sites (due to the shortened timeline described above). Once we shifted the focus to our patients/team needs and what works we did an amazing job of ramping up fast and identifying future potential.
Project Improvement	For Project improvement, our team was very able to take life in stride and adjust to meet patient needs. I don't feel as though anyone anticipated COVID, but I almost feel as though we adapted quickly to help patients, providers, and our team in integrating the team into

patient care. I think we actually ended up in a better place due to covid because that is when we shifted the focus to meeting our own clinic/patient needs.

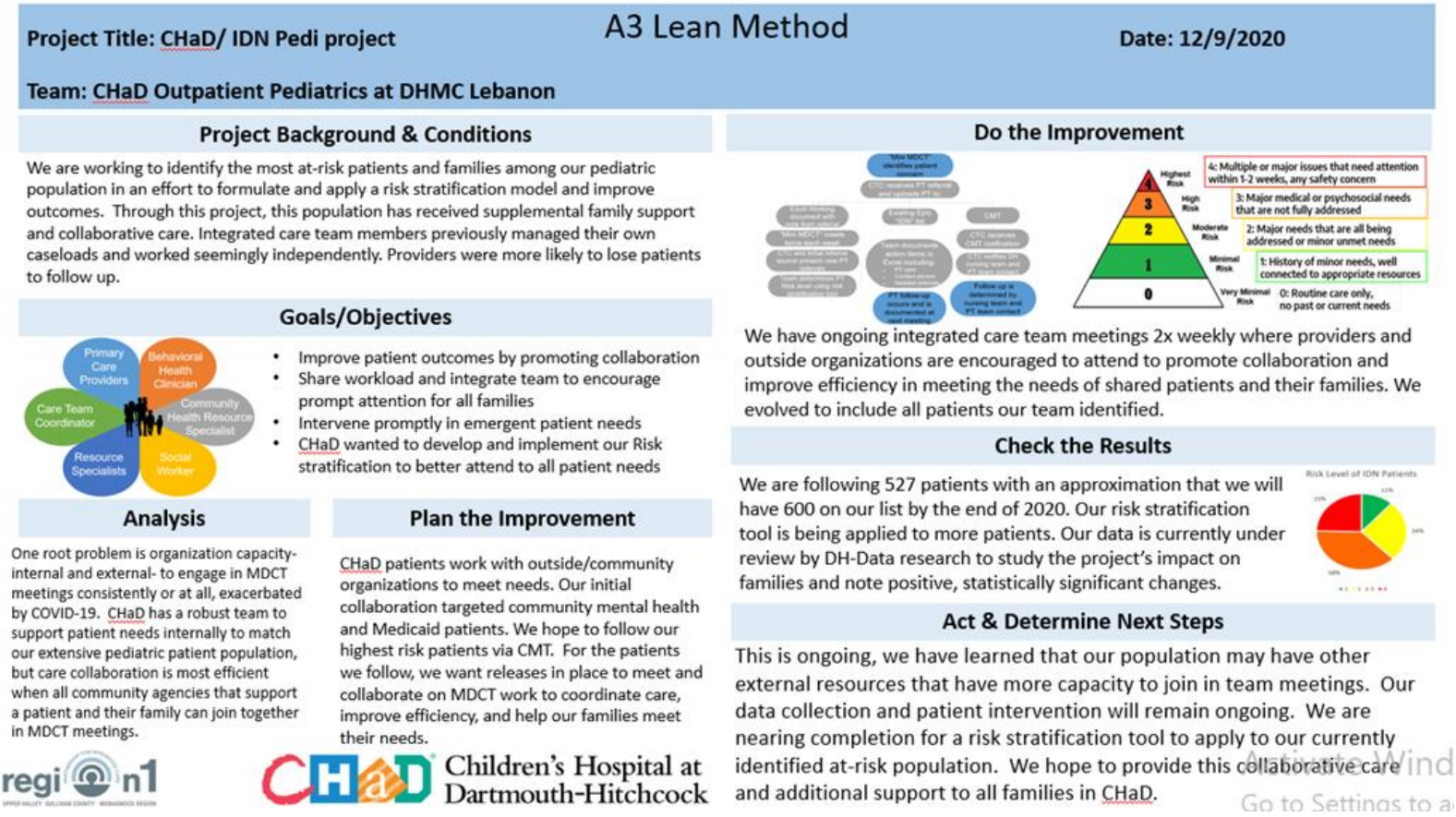
Transition Planning

24. Are there actions/resources you need from the IDN administration for transitioning?
25. Are there actions/resources you need from your regional partners before transitioning (healthcare provider, behavioral health provider, community support agency, other)?
26. Are there actions/resources you need on a state level before transitioning (DHHS, other IDNS, other)?

We do need some funding to be able to continue, wherever that comes from.

Open communication about statewide initiatives for sustainability. Community agencies allocating resources for collaborative efforts as we transition to a more diverse wraparound care system.

Continued funding as it would be my speculation that we have a lot of beneficial project work that may fall to the wayside.



The Dartmouth Hitchcock Pediatric team will be participating in the B1 contract extensions for the 2021 calendar year. The extension enabled the team to retain both their care team coordinator and community health worker. The team is appreciative of this funding as they believe both positions are valuable to improved patient care and provider satisfaction. One primary care provider has reported they feel comfortable going on vacation as they feel the system they have built will prevent their patients from falling through the cracks in their absence.

B1 Valley Regional Hospital Primary Care Practice (VRH)

Current State: July 1, 2020 – December 31, 2020

The Valley Regional Hospital team continues deploy the Comprehensive Core Standardized Assessment (CCSA) and conduct the Multidisciplinary Care Team Meetings (MDCT) with Shared Care Plans (SCP). They continue to build their partnerships with external organizations. With the ongoing pressure and demand on the clinics due to Covid, one of the practices began to fall away from the designed process for the CCSA. When the project team met in October the occurrence was disclosed, leadership worked with the practice to get the process back on track. Additionally, the project team is working on updating their CCSA with additional evidence based questions they feel will help to better indicate what resources the patient needs and make their screening and follow-up process more efficient. The new version is planned to be finalized and implemented in 2021.

During the reporting period they conducted what they refer to as a "Mega MDCT" for a pediatric case which involved over five external partners including the school. The VRH team members reported this as valuable as it allowed for the deduplication of efforts and allowed for better coordination across the multiple entities. With ongoing clinical challenges with Covid-19, the team has experienced a decrease in new cases presented at the Multi-Disciplinary Care Team. This is likely due to the resource constraint in the outpatient setting, as well as a focus on their mega MDCT. The data table below shows their MDCT and SCPs for the year.

Valley Regional Primary Care			
1st Quarter 2020	**January**	**February**	**March**
Number of MDCTs Mtgs	4	4	4
Number of New SCPs	0	1	1
Number of Reoccuring SCPs	7	7	8
Number of External Partners	3	3	3
Number of closed SCPs	0	0	0
2nd Quarter 2020	**April**	**May**	**June**
Number of MDCTs Mtgs	2	2	2
Number of New SCPs	0	0	1
Number of Reoccuring SCPs	9	9	9
Number of External Partners	3	3	4
Number of closed SCPs	0	0	0
3rd Quarter 2020	**July**	**August**	**September**
Number of MDCTs Mtgs	2	2	2
Number of New SCPs	0	0	0
Number of Reoccuring SCPs	10	9	5
Number of External Partners	4	4	4
Number of closed SCPs	0	1	4
4th Quarter 2020	**October**	**November**	**December**
Number of MDCTs Mtgs	2	3	3
Number of New SCPs	0	1	0
Number of Reoccuring SCPs	4	4	5
Number of External Partners	8	8	8
Number of closed SCPs	0	0	0

The VRH team continued to collect the results of their CCSA in a registry. This has allowed them to track data and progress on a patient level, while also allowing them to review it on a population health level. The team has not yet determined formal plans for utilizing the data for population health, however they have identified it as a long term goal. As they are able, they do share the data with their community partners. The data from the registry can be found below. They present in tables collated by adult CCSA results, parent CCSA results and youth CCSAs results.

Table 1 – **Overall: See Zoomed sections on next page**

ADULT PATIENTS 2019 vs. 2020			Q1: What is your housing situation today?		Q2: In your housing situation, do you have issues with any of the following?														Q3: Lack of transp. kept from med. appts, mtgs, getting daily living things?		Q4: If somewhat hard or very hard, what do you have trouble paying for?												Q5: Felt unable to afford your medications?		Q6: Felt need to sell medications for food, housing, heat, etc?		Q8: Do you drink alcohol or use non-prescribed drugs? If no, skip CAGE		Q14: In the past 12 months, have you been forced to perform sexual acts?		Q15: Do you have legal issues that are getting in the way of your health or healthcare?		# of patients with PHQ-A scoring 10 or higher		# of patients with GAD-7 scoring 10 or higher	
2019	Month	2020			nonworking stove/oven		Bug Infestation		Mold		Lead Paint/Pipes		Water Leaks		Not enough hot water		No smoke detectors		Other				Food		Housing		Childcare		Health Need		Utility Bills		Debts		Other																	
			2019	2020	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020
10	January	75	4	12	0	1	1	1	0	4	0	0	0	5	0	2	0	2	2	2	3	13	2	18	2	18	0	1	2	7	1	22	2	18	1	5	2	8	0	1	0	20	1	7	1	2	2	30	1	26
10	February	66	2	8	0	1	1	3	1	8	0	1	0	4	0	5	0	3	0	7	3	12	1	19	1	9	0	2	1	11	1	17	1	14	1	9	0	7	0	1	3	16	0	2	1	1	0	15	0	15
7	March	24	1	6	0	0	0	1	0	1	0	1	0	1	0	0	0	0	0	2	1	3	1	4	2	3	0	0	1	2	2	4	1	2	1	2	2	2	0	0	4	2	1	3	1	1	2	7	1	6
20	April	0	4	0	0	0	0	0	2	0	0	0	0	0	3	0	1	0	0	0	3	0	5	0	2	0	0	0	3	0	6	0	4	0	1	0	5	0	0	0	4	0	3	0	0	0	4	0	5	0
26	May	1	3	0	1	0	0	0	1	0	0	0	0	0	1	0	1	0	1	0	4	0	5	0	1	0	1	0	3	0	5	0	2	0	4	0	5	0	0	0	5	0	1	0	1	0	13	0	7	0
43	June	35	9	1	0	0	0	1	0	1	1	1	2	0	0	0	0	2	2	0	6	5	8	4	9	3	1	1	8	1	12	5	10	5	6	0	7	2	0	0	15	9	3	1	3	0	18	8	17	5
33	July	12	3	2	1	0	1	1	1	0	2	0	1	0	1	0	1	1	3	0	5	2	9	2	7	2	3	0	9	1	12	2	8	1	1	0	6	0	0	0	14	3	2	1	2	0	16	4	13	2
49	August	9	6	1	0	0	0	0	2	0	0	2	1	0	1	0	3	0	0	0	10	2	6	3	6	2	3	2	8	1	10	5	5	2	3	2	7	2	0	0	18	3	3	0	1	0	17	5	17	4
24	September	17	4	3	0	1	0	1	1	1	0	0	1	0	0	1	1	0	2	0	1	4	8	3	6	4	0	0	2	2	8	4	6	1	2	2	3	2	0	0	7	4	5	0	1	1	13	4	10	5
16	October	10	4	1	1	0	1	0	0	1	0	0	0	1	0	0	0	0	0	0	8	2	4	4	5	4	0	1	2	2	6	3	4	3	2	1	3	1	0	1	7	0	3	1	1	1	8	5	8	5
46	November	57	7	4	2	0	0	1	1	1	2	0	4	1	1	1	0	1	2	2	7	5	15	8	7	8	3	2	10	7	9	11	5	6	2	6	9	3	0	1	6	18	6	6	4	1	19	9	19	13
25	December	31	4	3	0	0	0	0	3	0	0	1	0	0	1	1	1	0	3	3	5	5	7	3	1	5	0	1	3	4	6	7	4	6	0	7	3	2	0	0	6	13	2	1	0	1	9	10	10	8
309	TOTALS	337	51	41	5	3	4	9	12	17	5	6	10	12	8	10	8	9	15	16	56	53	71	68	49	58	11	10	52	38	78	80	52	58	24	34	52	29	0	4	89	88	30	22	16	8	121	97	108	89
			16.5%	12.2%	1.6%	0.9%	1.3%	2.7%	3.9%	5.0%	1.6%	1.8%	3.2%	3.6%	2.6%	3.0%	2.6%	2.7%	4.9%	4.7%	18.1%	15.7%	23.0%	20.2%	15.9%	17.2%	3.6%	3.0%	16.8%	11.3%	25.2%	23.7%	16.8%	17.2%	7.8%	10.1%	16.8%	8.6%	0.0%	1.2%	28.8%	26.1%	9.7%	6.5%	5.2%	2.4%	39.2%	28.8%	35.0%	26.4%

Table 1 – Cut in half, left side

ADULT PATIENTS 2019 vs. 2020			Q1: What is your housing situation today?		Q2: In your housing situation, do you have issues with any of the following?														Q3: Lack of transp. kept from med. appts, mtgs, getting daily living things?		Q4: If somewhat hard or very hard, what do you have trouble paying for?																	
2019	Month	2020			nonworking stove/oven		Bug Infestation		Mold		Lead Paint/Pipes		Water Leaks		Not enough hot water		No smoke detectors		Other				Food		Housing		Childcare		Health Need		Utility Bills		Debts		Other																	
			2019	2020	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020
10	January	75	4	12	0	1	1	1	0	4	0	0	0	5	0	2	0	2	2	2	3	13	2	18	2	18	0	1	2	7	1	22	2	18	1	5	2	8	0	1	0	20	1	7	1	2	2	30	1	26
10	February	66	2	8	0	1	1	3	1	8	0	1	0	4	0	5	0	3	0	7	3	12	1	19	1	9	0	2	1	11	1	17	1	14	1	9	0	7	0	1	3	16	0	2	1	1	0	15	0	15
7	March	24	1	6	0	0	0	1	0	1	0	1	0	1	0	0	0	0	0	2	1	3	1	4	2	3	0	0	1	2	2	4	1	2	1	2	2	2	0	0	4	2	1	3	1	1	2	7	1	6
20	April	0	4	0	0	0	0	0	2	0	0	0	0	0	3	0	1	0	0	0	3	0	5	0	2	0	0	0	3	0	6	0	4	0	1	0	5	0	0	0	4	0	3	0	0	0	4	0	5	0
26	May	1	3	0	1	0	0	0	1	0	0	0	0	0	1	0	1	0	1	0	4	0	5	0	1	0	1	0	3	0	5	0	2	0	4	0	5	0	0	0	5	0	1	0	1	0	13	0	7	0
43	June	35	9	1	0	0	0	1	0	1	1	1	2	0	0	0	0	2	2	0	6	5	8	4	9	3	1	1	8	1	12	5	10	5	6	0	7	2	0	0	15	9	3	1	3	0	18	8	17	5
33	July	12	3	2	1	0	1	1	1	0	2	0	1	0	1	0	1	1	3	0	5	2	9	2	7	2	3	0	9	1	12	2	8	1	1	0	6	0	0	0	14	3	2	1	2	0	16	4	13	2
49	August	9	6	1	0	0	0	0	2	0	0	2	1	0	1	0	3	0	0	0	10	2	6	3	6	2	3	2	8	1	10	5	5	2	3	2	7	2	0	0	18	3	3	0	1	0	17	5	17	4
24	September	17	4	3	0	1	0	1	1	1	0	0	1	0	0	1	1	0	2	0	1	4	8	3	6	4	0	0	2	2	8	4	6	1	2	2	3	2	0	0	7	4	5	0	1	1	13	4	10	5
16	October	10	4	1	1	0	1	0	0	1	0	0	0	1	0	0	0	0	0	0	8	2	4	4	5	4	0	1	2	2	6	3	4	3	2	1	3	1	0	1	7	0	3	1	1	1	8	5	8	5
46	November	57	7	4	2	0	0	1	1	1	2	0	4	1	1	1	0	1	2	2	7	5	15	8	7	8	3	2	10	7	9	11	5	6	2	6	9	3	0	1	6	18	6	6	4	1	19	9	19	13
25	December	31	4	3	0	0	0	0	3	0	0	1	0	0	1	1	1	0	3	3	5	5	7	3	1	5	0	1	3	4	6	7	4	6	0	7	3	2	0	0	6	13	2	1	0	1	9	10	10	8
309	TOTALS	337	51	41	5	3	4	9	12	17	5	6	10	12	8	10	8	9	15	16	56	53	71	68	49	58	11	10	52	38	78	80	52	58	24	34	52	29	0	4	89	88	30	22	16	8	121	97	108	89
			16.5%	12.2%	1.6%	0.9%	1.3%	2.7%	3.9%	5.0%	1.6%	1.8%	3.2%	3.6%	2.6%	3.0%	2.6%	2.7%	4.9%	4.7%	18.1%	15.7%	23.0%	20.2%	15.9%	17.2%	3.6%	3.0%	16.8%	11.3%	25.2%	23.7%	16.8%	17.2%	7.8%	10.1%	16.8%	8.6%	0.0%	1.2%	28.8%	26.1%	9.7%	6.5%	5.2%	2.4%	39.2%	28.8%	35.0%	26.4%

Table 1 – Cut in half, right side

Q5: Felt unable to afford your medications?		Q6: Felt need to sell medications for food, housing, heat, etc?		Q8: Do you drink alcohol or use non-prescribed drugs? **If no, skip CAGE**		Q14: In the past 12 months, have you been forced to perform sexual acts?		Q15: Do you have legal issues that are getting in the way of your health or healthcare?		# of patients with PHQ-A scoring 10 or higher		# of patients with GAD-7 scoring 10 or higher	
2019	2020	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020
2	8	0	1	0	20	1	7	1	2	2	30	1	26
0	7	0	1	3	16	0	2	1	1	0	15	0	15
2	2	0	0	4	2	1	3	1	1	2	7	1	6
5	0	0	0	4	0	3	0	0	0	4	0	5	0
5	0	0	0	5	0	1	0	1	0	13	0	7	0
7	2	0	0	15	9	3	1	3	0	18	8	17	5
6	0	0	0	14	3	2	1	2	0	16	4	13	2
7	2	0	0	18	3	3	0	1	0	17	5	17	4
3	2	0	0	7	4	5	0	1	1	13	4	10	5
3	1	0	1	7	0	3	1	1	1	8	5	8	5
9	3	0	1	6	18	6	6	4	1	19	9	19	13
3	2	0	0	6	13	2	1	0	1	9	10	10	8
52	**29**	**0**	**4**	**89**	**88**	**30**	**22**	**16**	**8**	**121**	**97**	**108**	**89**
16.8%	8.6%	0.0%	1.2%	28.8%	26.1%	9.7%	6.5%	5.2%	2.4%	39.2%	28.8%	35.0%	26.4%

Table 2 - Overview

Parents of Pediatric Patients			Q1: What is your family's housing situation today? *Answers other than safe and secure*		Q2: Yes, my child lives in more than one family home?		Q3: In your housing situation, do you have issues with any of the following? nonworking stove/oven		Bug Infestation		Mold		Lead Paint/Pipes		Water Leaks		Not enough hot water		No smoke detectors		Other	
2019	Month	2020	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020
	January	52		1		7		1		1		2		1		2		2		0		1
	February	21		0		1		0		0		0		1		1		1		0		0
	March	18		0		2		0		0		0		0		1		0		1		0
	April	0		0		0		0		0		0		0		1		0		1		1
54	May	1	7	0	6	0	1	0	0	0	0	0	5	0	0	0	0	0	0	0	0	0
80	June	28	1	0	15	4	1	0	3	0	1	2	0	2	1	0	0	0	0	1	0	0
65	July	49	2	2	16	9	0	0	0	2	3	1	0	2	3	1	0	0	0	0	0	1
74	August	44	3	2	10	6	0	0	0	1	1	1	1	2	0	0	0	0	0	0	0	0
71	September	67	5	4	10	9	0	0	0	2	0	2	3	0	0	0	1	0	0	1	1	1
50	October	57	2	2	4	6	0	0	0	0	0	0	1	1	0	0	0	1	0	0	0	1
53	November	60	2	2	9	9	0	1	0	1	0	3	3	2	0	1	0	1	0	2	0	0
33	December	53	0	15	3	7	0	0	0	0	0	0	0	2	0	0	1	0	0	0	1	0
480	**TOTALS**	**450**	**22**	**28**	**73**	**60**	**2**	**2**	**3**	**7**	**5**	**11**	**13**	**13**	**4**	**7**	**2**	**5**	**0**	**6**	**2**	**5**
			4.6%	6.2%	15.2%	13.3%	0.0%	0.4%	0.6%	0.4%	1.0%	2.4%	2.7%	2.9%	0.8%	1.6%	0.0%	15.2%	0.0%	1.3%	0.4%	1.1%

Month	Q4: Lack of transport. kept you or your child from med appts, mtgs, work?		Q5: If somewhat hard or very hard, what do you have trouble paying for? Food		Housing		Childcare		Health Need		Utility Bills		Debts		Other	
	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020
January		6		8		8		3		3		10		7		2
February		0		3		0		1		0		3		1		0
March		0		0		0		0		0		5		3		1
April		0		0		0		0		0		0		0		0
May	7	0	5	0	1	0	2	0	1	0	6	0	6	0	2	0
June	1	1	10	1	5	0	4	0	8	1	15	3	9	4	5	0
July	2	2	9	3	1	2	2	3	1	1	7	6	4	3	1	1
August	0	1	9	1	2	5	1	5	2	1	15	4	10	2	1	0
September	2	3	10	5	4	7	3	3	1	1	12	13	3	2	3	2
October	1	2	6	7	6	3	3	2	1	0	11	6	7	3	1	0
November	1	1	3	12	1	6	1	5	0	1	7	15	2	3	0	4
December	0	6	3	8	3	4	1	4	0	0	4	9	3	7	0	3
TOTALS	**14**	**22**	**55**	**48**	**23**	**35**	**17**	**26**	**14**	**8**	**77**	**74**	**44**	**35**	**13**	**13**
	2.9%	4.9%	11.5%	10.7%	4.8%	7.8%	3.5%	5.8%	2.9%	1.8%	16.0%	16.4%	9.2%	7.8%	2.7%	2.9%

Month	Q8: In the past 12 months, have you been threatened or scared by another		Q9: In the past 12 months, have you been forced to perform sexual acts?		Q10: Do you have legal issues that are getting in the way of your health or healthcare?		Q13: Does your child have an IEP or 504 plan in place at school?		Q14: Does your child receive counseling?		Q17: Struggle to provide: Breakfast at Home		Fruit & Vegetables		Exercise & Physical Activity		Q19: During the past 2 weeks, has your child shown any of the following?	
	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020
January		1		0		0		8		5		5		4		0		1
February		1		0		0		4		2		0		3		0		1
March		1		0		0		4		2		2		1		1		1
April		0		0		0		0		0		0		0		0		0
May	3	0	0	0	0	0	13	0	5	0	2	0	6	0	4	0	2	0
June	1	1	1	0	0	0	12	5	11	1	1	0	7	0	6	3	8	1
July	2	4	0	0	1	1	10	11	7	4	2	1	5	1	3	2	7	1
August	2	0	0	0	0	2	20	11	10	3	1	1	7	2	2	1	3	0
September	2	4	0	0	0	1	15	10	4	3	1	2	2	3	1	1	4	1
October	0	0	0	0	0	0	12	7	4	1	2	3	3	4	4	2	3	1
November	2	2	1	0	1	1	11	16	4	9	1	3	1	6	1	1	4	5
December	2	1	1	0	0	0	9	11	3	5	1	1	2	1	0	3	2	3
TOTALS	**14**	**15**	**3**	**0**	**2**	**5**	**102**	**87**	**48**	**35**	**11**	**18**	**33**	**25**	**21**	**14**	**33**	**15**
	2.9%	3.3%	0.6%	0.0%	0.0%	1.1%	21.3%	19.3%	10.0%	7.8%	2.3%	4.0%	6.9%	5.6%	4.4%	3.1%	7.3%	3.3%

Table 2 – Cut in half, left side

Parents of Pediatric Patients			Q1: What is your family's housing situation today? *Answers other than safe and secure*		Q2: Yes, my child lives in more than one family home?		Q3: In your housing situation, do you have issues with any of the following?														Q4: Lack of transport. kept you or your child from med appts, mtgs, work?		Q5: If somewhat hard or very hard, what do you have trouble paying for?													
			nonworking stove/oven		Bug Infestation		Mold		Lead Paint/Pipes		Water Leaks		Not enough hot water		No smoke detectors		Other						Food		Housing		Childcare		Health Need		Utility Bills		Debts		Other	
2019	Month	2020	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020
	January	52		1		7		1		1		2		1		2		2		0		1		6		8		8		3		3		10		7		2
	February	21		0		1		0		0		0		1		1		1		0		0		0		3		0		1		0		3		1		0
	March	18		0		2		0		0		0		0		1		0		1		0		0		0		0		0		0		5		3		1
	April	0		0		0		0		0		0		0		1		0		1		1		0		0		0		0		0		0		0		0
54	May	1	7	0	6	0	1	0	0	0	0	0	5	0	0	0	0	0	0	0	0	0	7	0	5	0	1	0	2	0	1	0	6	0	6	0	2	0
80	June	28	1	0	15	4	1	0	3	0	1	2	0	2	1	0	0	0	0	1	0	0	1	1	10	1	5	0	4	0	8	1	15	3	9	4	5	0
65	July	49	2	2	16	9	0	0	0	2	3	1	0	2	3	1	0	0	0	0	0	1	2	2	9	3	1	2	2	3	1	1	7	6	4	3	1	1
74	August	44	3	2	10	6	0	0	0	1	1	1	1	2	0	0	0	0	0	0	0	0	0	1	9	1	2	5	1	5	2	1	15	4	10	2	1	0
71	September	67	5	4	10	9	0	0	0	2	0	2	3	0	0	0	1	0	0	1	1	1	2	3	10	5	4	7	3	3	1	1	12	13	3	2	3	2
50	October	57	2	2	4	6	0	0	0	0	0	0	1	1	0	0	0	1	0	0	0	1	1	2	6	7	6	3	3	2	1	0	11	6	7	3	1	0
53	November	60	2	2	9	9	0	1	0	1	0	3	3	2	0	1	0	1	0	2	0	0	1	1	3	12	1	6	1	5	0	1	7	15	2	3	0	4
33	December	53	0	15	3	7	0	0	0	0	0	0	0	2	0	0	1	0	0	0	1	0	0	6	3	8	3	4	1	4	0	0	4	9	3	7	0	3
480	TOTALS	450	22	28	73	60	2	2	3	7	5	11	13	13	4	7	2	5	0	6	2	5	14	22	55	48	23	35	17	26	14	8	77	74	44	35	13	13
			4.6%	6.2%	15.2%	13.3%	0.0%	0.4%	0.6%	0.4%	1.0%	2.4%	2.7%	2.9%	0.8%	1.6%	0.0%	15.2%	0.0%	1.3%	0.4%	1.1%	2.9%	4.9%	11.5%	10.7%	4.8%	7.8%	3.5%	5.8%	2.9%	1.8%	16.0%	16.4%	9.2%	7.8%	2.7%	2.9%

Table 2 – Cut in half, right side

Q8: In the past 12 months, have you been threatened or scared by another		Q9: In the past 12 months, have you been forced to perform sexual acts?		Q10: Do you have legal issues that are getting in the way of your health or healthcare?		Q13: Does your child have an IEP or 504 plan in place at school?		Q14: Does your child receive counseling?		Q17: Struggle to provide:						Q19: During the past 2 weeks, has your child shown any of the following?	
										Breakfast at Home		Fruit & Vegetables		Exercise & Physical Activity			
2019	2020	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020
	1		0		0		8		5		5		4		0		1
	1		0		0		4		2		0		3		0		1
	1		0		0		4		2		2		1		1		1
	0		0		0		0		0		0		0		0		0
3	0	0	0	0	0	13	0	5	0	2	0	6	0	4	0	2	0
1	1	1	0	0	0	12	5	11	1	1	0	7	0	6	3	8	1
2	4	0	0	1	1	10	11	7	4	2	1	5	1	3	2	7	1
2	0	0	0	0	2	20	11	10	3	1	1	7	2	2	1	3	0
2	4	0	0	0	1	15	10	4	3	1	2	2	3	1	1	4	1
0	0	0	0	0	0	12	7	4	1	2	3	3	4	4	2	3	1
2	2	1	0	1	1	11	16	4	9	1	3	1	6	1	1	4	5
2	1	1	0	0	0	9	11	3	5	1	1	2	1	0	3	2	3
14	15	3	0	2	5	102	87	48	35	11	18	33	25	21	14	33	15
2.9%	3.3%	0.6%	0.0%	0.0%	1.1%	21.3%	19.3%	10.0%	7.8%	2.3%	4.0%	6.9%	5.6%	4.4%	3.1%	7.3%	3.3%

YOUTH PATIENTS			Q1: Drink alcohol? (more than few sips)		Q2: Smoke marijuana or hashish?		Q3: Use anything else to get high?		Do you smoke, chew, vape nicotine products?		Q1: Been in car driven by person high or had been drinking?		Q2: Use alcohol or drugs to relax, feel better about yourself, or fit in?		Q3: Use alcohol or drugs while you are by yourself or alone?		Q4: Forget things you did while using alcohol or drugs?		Q5: Family or friends ever tell you that you should cut down on your drinking or drug use?		Q6: In trouble while you were using drugs?		Q1: Felt depressed or sad most days, even if you felt okay sometimes?		Q2: In past month have had serious thoughts about ending your life?		Q3: Tried to kill yourself or made a suicide attempt?		# Patients with PHQ-9 scored 10 or higher		# Patients with GAD-7 scored 10 or higher	
2019	**Month**	**2020**	**2019**	**2020**	**2019**	**2020**	**2019**	**2020**	**2019**	**2020**	**2019**	**2020**	**2019**	**2020**	**2019**	**2020**	**2019**	**2020**	**2019**	**2020**	**2019**	**2020**	**2019**	**2020**	**2019**	**2020**	**2019**	**2020**	**2019**	**2020**	**2019**	**2020**
	January	16		0		1		0		1		1		0		0		0		0		1		7		2		0		6		5
	February	5		0		0		0		0		0		0		0		0		0		0		2		0		0		1		2
	March	7		0		0		0		0		0		0		0		0		0		0		3		1		1		2		1
	April	0		0		0		0		0		0		0		0		0		0		0		0		0		0		0		0
12	May	0	0	0	0	0	0	0	0	0	2	0	0	0	0	0	0	0	1	0	0	0	7	0	1	0	0	0	2	0	2	0
24	June	9	1	0	5	0	0	0	0	0	1	0	2	0	2	0	1	0	1	0	1	0	10	1	4	1	2	0	8	1	7	1
17	July	8	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	8	4	2	1	5	1	5	3	6	4
21	August	17	0	1	2	1	0	0	0	1	1	0	0	0	0	0	1	0	0	0	0	0	4	5	0	0	1	2	4	2	4	3
24	September	31	3	2	0	1	0	0	1	1	2	0	0	2	0	1	0	1	0	0	0	0	9	5	3	0	0	2	4	2	4	3
16	October	35	0	1	1	1	0	0	0	1	3	0	1	0	1	1	0	0	0	1	0	8	8	8	2	2	2	1	4	5	6	4
13	November	20	1	2	2	2	0	0	1	1	1	0	2	1	2	0	0	0	1	0	0	0	9	7	1	3	2	1	4	5	2	4
6	December	21	0	1	0	2	0	0	0	0	0	1	0	0	0	0	0	0	0	1	0	1	2	6	1	1	0	1	1	7	2	5
133	**TOTALS**	**169**	**5**	**7**	**11**	**9**	**0**	**0**	**2**	**5**	**10**	**2**	**5**	**3**	**5**	**2**	**2**	**1**	**3**	**2**	**1**	**10**	**57**	**48**	**14**	**11**	**12**	**9**	**32**	**34**	**33**	**32**
			3.8%	4.1%	8.3%	5.3%	0.0%	0.0%	1.5%	3.0%	7.5%	1.2%	3.8%	1.8%	3.8%	1.2%	1.5%	0.6%	2.3%	1.2%	0.8%	5.9%	42.9%	28.4%	10.5%	6.5%	9.0%	5.3%	24.1%	20.1%	24.8%	18.9%

A3 Lean Method

Project Title: Valley Regional Primary Care **Date: 12/16/2020**

Team: Dr. Julianne Barrett, Krista Lafont-Leamey, Danielle Tenney, Lexi Bly

Project Background

Over 3-years VRH will establish innovative and collaborative relationships with behavioral health providers and community partners; create effective and efficient procedures and workflows; and shift traditional thinking to embrace a multi-faceted approach to mental health and primary care integration.

Current Conditions

* No capacity or resources to identify and assist with patients' social needs
* No screening tools or workflows for identifying patient needs
* No collaboration between BH partners: WCBH & Counseling Associates.
* Patients' social needs make it difficult to access health resources
* Referrals made to outside agencies ➡ unknown outcomes

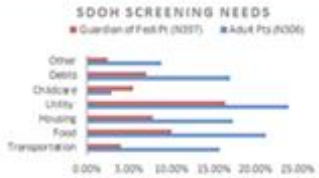
Goals/Objectives & Analysis

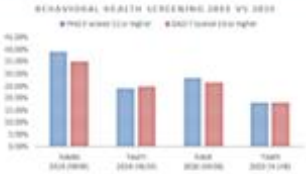
Plan the Improvement

Do the Improvement

* Hired (2) MSW, (1) Collaborative Care RN & (1) Community Health Navigator positions
* Secured project coordinator/facilitator & conducted 2x/month B1 team meetings
* Designed & Implemented (3) SDoH patient assessment (CCSA) versions
* Created Pediatric & Adult "Pathways" to correspond with positive CCSA responses
* Established data registry for documenting all CCSA responses
* Identified & Improved workflows for patient check-in, MDCT/SCP and Mental Health partner communication collaborations
* Launched successful model in (3) VRH primary care practices

Check the Results

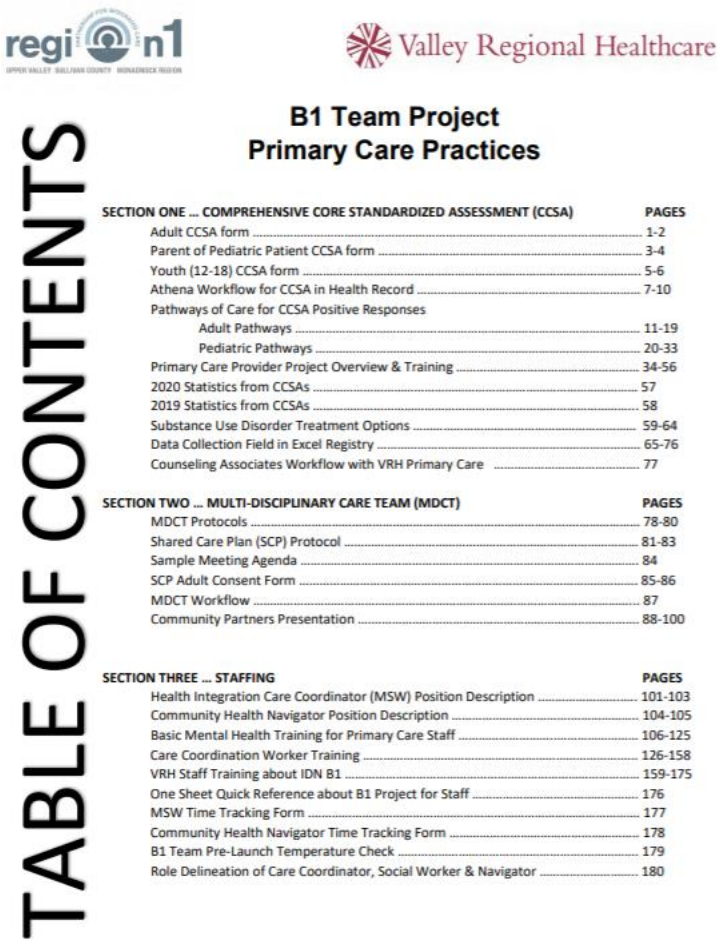




Act & Determine Next Steps & Analysis

1) Analyzing & Revamping Patient Intake Process
2) Increasing Sustainability – Licensure of MSWs & Billing Process
3) Reviewing No-Show Policy
4) Post COVID-19 exploratory of group therapy model

The VRH team completed the A3 (above) as well as created a playbook which represents a collation of all their work over the project term. The documents are below, excluding a portion of the playbook due to the length. Included for the playbook is the table of contents outlining what they included.



region1

Valley Regional Healthcare

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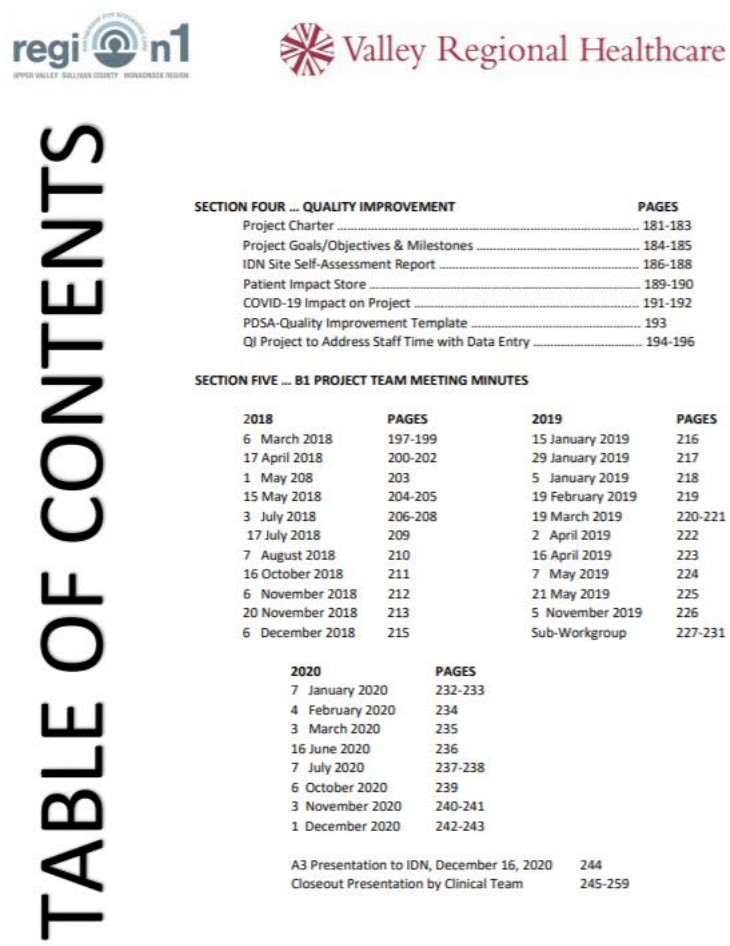
B1 Team Project
Primary Care Practices



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The VRH team will be continuing with the Region 1 IDN extended B1 2021 contract. The team will continue to focus on improvement of all IDN project elements as well as continued focus on long term program sustainability. The team plans on meeting early on with the team at West Central Behavioral Health to develop a plan on continued improvement in communication and process and how they can financially sustain the work port IDN funding.

B1 Cheshire Medical Center (CMC) Adult Primary Care Practice /Monadnock Family Services (MFS) bi-directional Integrated Care Project Updates

Historical Context: A collaborative bi-directional integration pilot housed at Monadnock Family Services (MFS) with support from Cheshire Medical Center (CMC) Primary Care. This project focuses on bidirectional integration with embedded primary care services available at MFS for their highest acuity patients. The project team began meeting in the summer of 2018. After hiring an APRN for the MFS clinic and finishing necessary environmental needs began seeing patient in April of 2019.

Current State: July 1, 2020 – December 31, 2020

The focus of the reporting period for the team was to continue to work towards sustainability and find data which would support the ongoing involvement of the program. The Community Mental Health Center (CMHC) Monadnock Family Services (MFS) has found the program to be very valuable as it allows them to have the integration with the onsite primary care provider. As the team reflected this period and completed their evaluation worksheet (below), one ongoing challenge they identified was how to better connect back with the primary care team at Cheshire Medical Center. The objectives originally set out by the team are outlined in the worksheet with notes indicating their ongoing process on the objective. Although the embedded primary care provider at MFS was a CMC employee, they had very little scheduled time at the organization. This led to the underdevelopment of relationships for the provider within CMC and ultimately caused a strain on clear communication. The team highlighted this as a goal for improvement in the New Year. In the latter half of the period, senior leaders from both organizations continued to discuss the sustainability of the program. Without support of an alternative payment model to continue the position sustainability, the primary care position embedded within the CMHC will transition into a part time position in the New Year, this is based mainly on the patient case load the provider has been holding steadily for the final few months of the year. Additionally, the team completed an A3 which highlighted their program implementation and improvement (below).

Goals

27. What where your original goals and expectations for the project?
28. Has your perception of the project changed overtime and did your goals changed as a result?
29. What goals were met/unmet (speak to goals which have progressed but have not fully been met)?
30. Do you have new or additional goals in achieving further integration?
31. Where/are your goals supported across your organization (clinicians, support staff, financial, management)?

Our original goals as developed in the Project Charter:

Objective 1: Create, test and refine a co-located "reverse integration" Health Home Model that integrates professional disciplines and shared resources, with clients and their families, intended to afford the best possible health outcome. **Results: Goal met, CMC hired the provider and he began seeing patients the middle of April 2020. For the period April 2019 – June 2020 services were provided to 166 unique clients, resulting in a total of 2,671 encounters. Because of Covid-19 how services were delivered change drastically beginning in March 2020. Many appointments were held via telehealth. In addition, based on the severity of the situation, Chris began offering home visits. The provider used a specific algorithm to determine if a home visit was necessary. When they occurred, at times he would be accompanied by either the nurse or MFS Case Manager, other times Chris would do the home visit alone. With Chris embedded at MFS, there has been very good coordination with the clinical teams at MFS and CMC family practice. Chris's approach is positive and supportive, he has the ability to meet people where they are at, not pass judgement and thereby create a supportive, positive relationship with the clients.**

Objective 2: Assure that every individual in the Health Home has a comprehensive plan of care that effectively addresses their physical and behavioral health needs with a coordinated approach. **Results: Partially met via the CMT shared care plan, as of reporting date there are 46 clients in CMT however only one that has a shared care plan active. What has been most effective for coordinating care between CMC and MFS has been Chris' participation in treatment team meetings with the MFS providers and his being a conduit of communication to**

CMC primary care providers. Chris has viewing access to the MFS EMR and our providers have reading rights to the CMC EPIC. Monthly MDCT meetings were happening pre-Covid, since March these meetings have not occurred. Efforts will be made to reestablish these meetings for the final three months of the project.

Objective 3: Assist individuals in the Health Home with acquiring skills for managing their chronic illnesses in ways that reduce unnecessary emergency care and inpatient hospitalization, to be accomplished by a combination of lifestyle coaching, building self-management skills, greater peer supports, and coordination of primary care and behavioral health service delivery. **Results: Goal Met- for clients that are seeing Chris, we have added the medical component to the ISP (individual service plan) at MFS. The ISP comprehensively addresses behavioral and medical health needs and identifies specific service providers and goals to address skill acquisition related to management of their chronic health conditions.**

Objective 4: Continuously improve client and staff experience (satisfaction and quality). **Results: Between Jan-march 2020 a client satisfaction survey was distributed to the client. 28 clients completed the survey with 95% responding either excellent/very good to "how satisfied are you with the amount of time Chris Polich spent with you", 92% rated the overall care received as excellent and 80% indicted they would most likely have done nothing if they were unable to see Chris. Staff surveys were completed during this same period of time, surveying MFS and CMC staff. Results reflect that MFS staff were much more knowledgeable abo the project than CMC staff, overall MFS scores were higher than CMC staff scores, and more CMC staff answered "does not apply" to questions than MFS staff. See attached slides for complete details of the staff and client survey results. In addition to this specific survey results, CMC Patient Experience result revealed several patients getting better care because of services at MFS.**

Objective 5: Utilize the Region 1 shared IT platform to ensure coordinated care and communication across partners and care sites. **Results: CMT shared care plan, as of reporting date there are 46 clients in CMT however only one that has a shared care plan active. With the one shared care plan that was uploaded it was apparent that this process would be very time consuming. Several meetings with all treatment providers and client were necessary to finalize the shared care plan. The Project Manager who is also the healthcare provider was charged with leaning this process. Given his lack of experience and unfamiliarity with the platform, it also created challenges to meet requirements. It is specifically noted that uploading clients in the system and develop shared care plans that are meaningful was challenging. There has been a steep learning curve to use the system effectively for the staff uploading the data and teaching other departments at CMC to use the system.**

Objective 6: Evaluate the project so that outcomes and lessons learned can be used to justify future replication and to advocate for payment reforms that could sustain this approach to Coordinated Care Practice. **Results: Minimal attention was given to this throughout the course of the project. As we near the end, the project team is working to identify successes and lessons learned which can be found below.**

Objective 7: Improving health outcomes

- Reducing ED visits
- Reduce hypertension rates
- Reduce uncontrolled diabetes rates
- Increase screening rates: colon cancer, mammography, immunizations (flu, pneumonia, tetanus, etc.)

Results: Upon provider hiring identification of these specific metrics were established. Unfortunately due to a lack of capacity and coordination with the Informatics team at CMC the project team has not received data on these specific metrics.

IDN Project Components

32. Do you feel you successfully implemented and improved these component?
  - **Is there further implementation/improvement to do?**

- **What barriers made it difficult to achieve or fully implement this component? What barriers will prevent sustainability (financial, leadership support, culture, staff, relationships, resources, other)?**
- **Was implementing this component valuable to how you care for patients and why?**
- **Did implementing this component enhance your professional satisfaction and relationships with coworkers, why?**
- **Are there adjustments needed to make this component more valuable? Could these components be synchronized with other organization initiatives?**
- **Are there materials missing or needing to be updated to complete the implementation (e.g., process flows, protocols, etc.)?**

There are many highlights and identification of several challenges in assessing the project over the duration. Though the project was scheduled to begin much earlier, because of the delay in hiring a provider and setting up the clinic space at the MFS building, the provider did not begin seeing patients until mid-April 2019. As with any new program, there was a ramp up of services. See attached spreadsheet for a summary of clients serviced from April 2019 – June 2020. During this period of time, services were provided to 166 unique clients; receiving a total of 2,671 encounters.

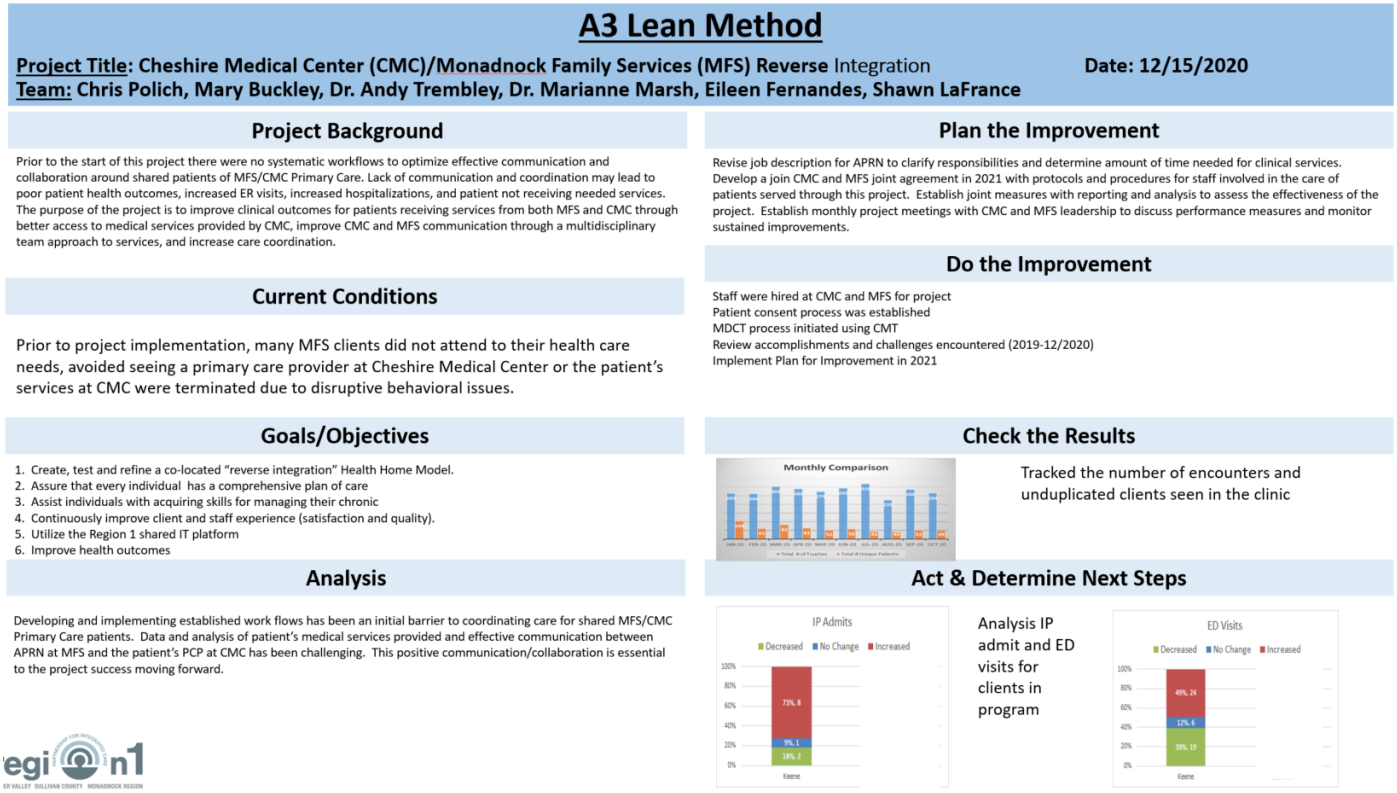
Positives:

- Identified intent to make services meaningful and useful to the clients – goal accomplished
- Clinic set up worked well, space was comfortable and inviting to clients
- Chris-the right person to work with the MFS clients; his approach is positive and engaging
- Being co-located with Genoa Pharmacy; positive working relationship with Kelly/pharmacist
- Access to EPIC worked well, sometimes internet connection was challenging
- MFS administrative support valuable
- Interaction between Chris and MFS clinical staff was valuable
- Increase accessibility for clients
- Monthly census use; billing for services

Challenges/barriers:

- Having a provider also responsible for the project management tasks did not work as planned when we put the proposal together.
- Provider connection and collaboration between Chris and providers at CMC, takes more time to establish working relationship since Chris was new to the system and the job
- Lack of clarity of role of Chris verses clinic providers: having clarity on roles responsibilities in writing in advance would have been helpful
- Process for getting supplies for MFS clinic site
- CMC Leadership changes caused delays and confusion regarding implementation of this project
- Intent of metrics monitoring: though we identified several key metrics, we were unable to create a registry.

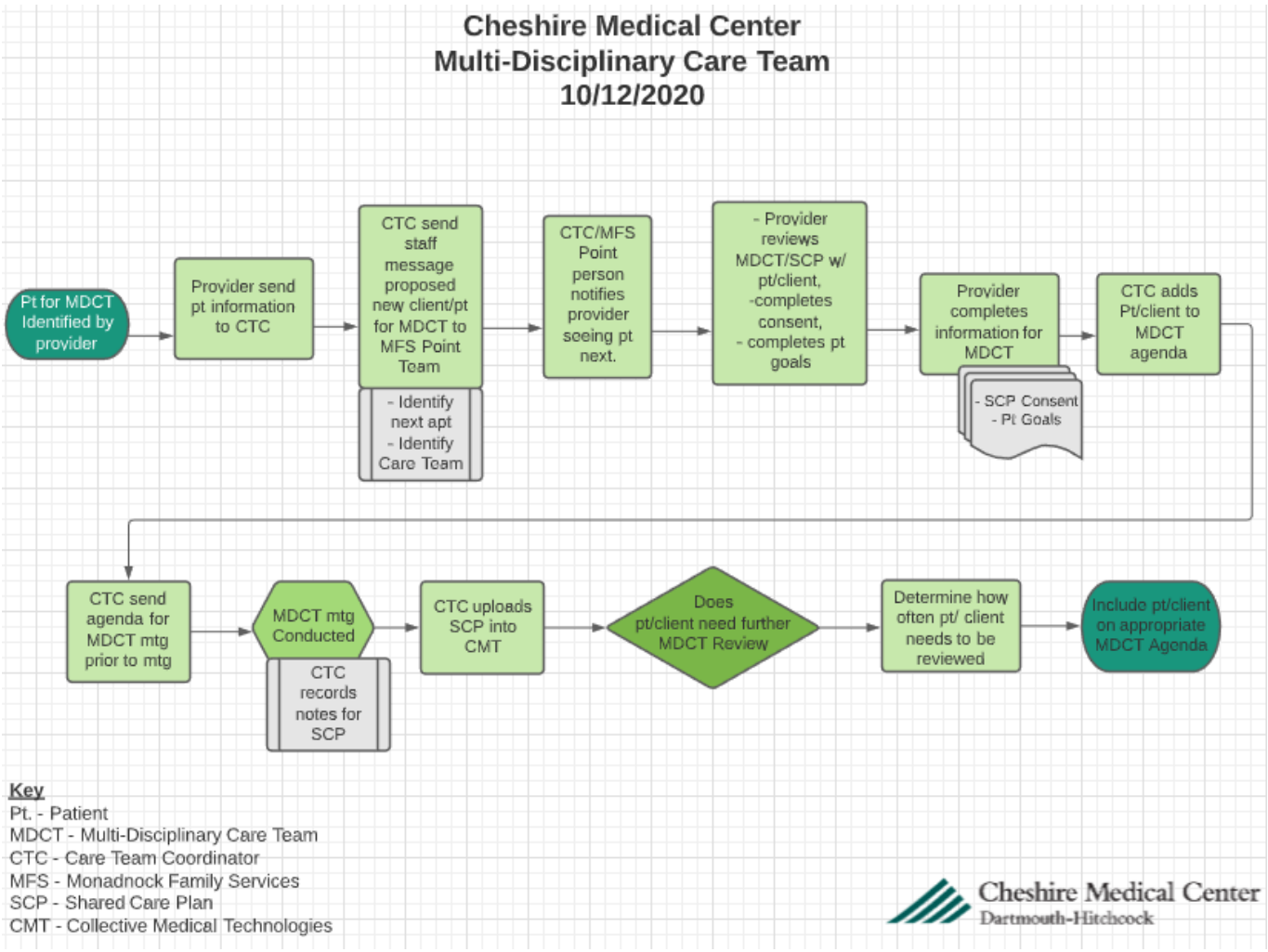
- Should have included the CMC Informatics team in our process for identifying metrics and data collection needs.
- Did we utilize the staff of the IDN to help with our challenges? We could have asked them for assistance more than we did.

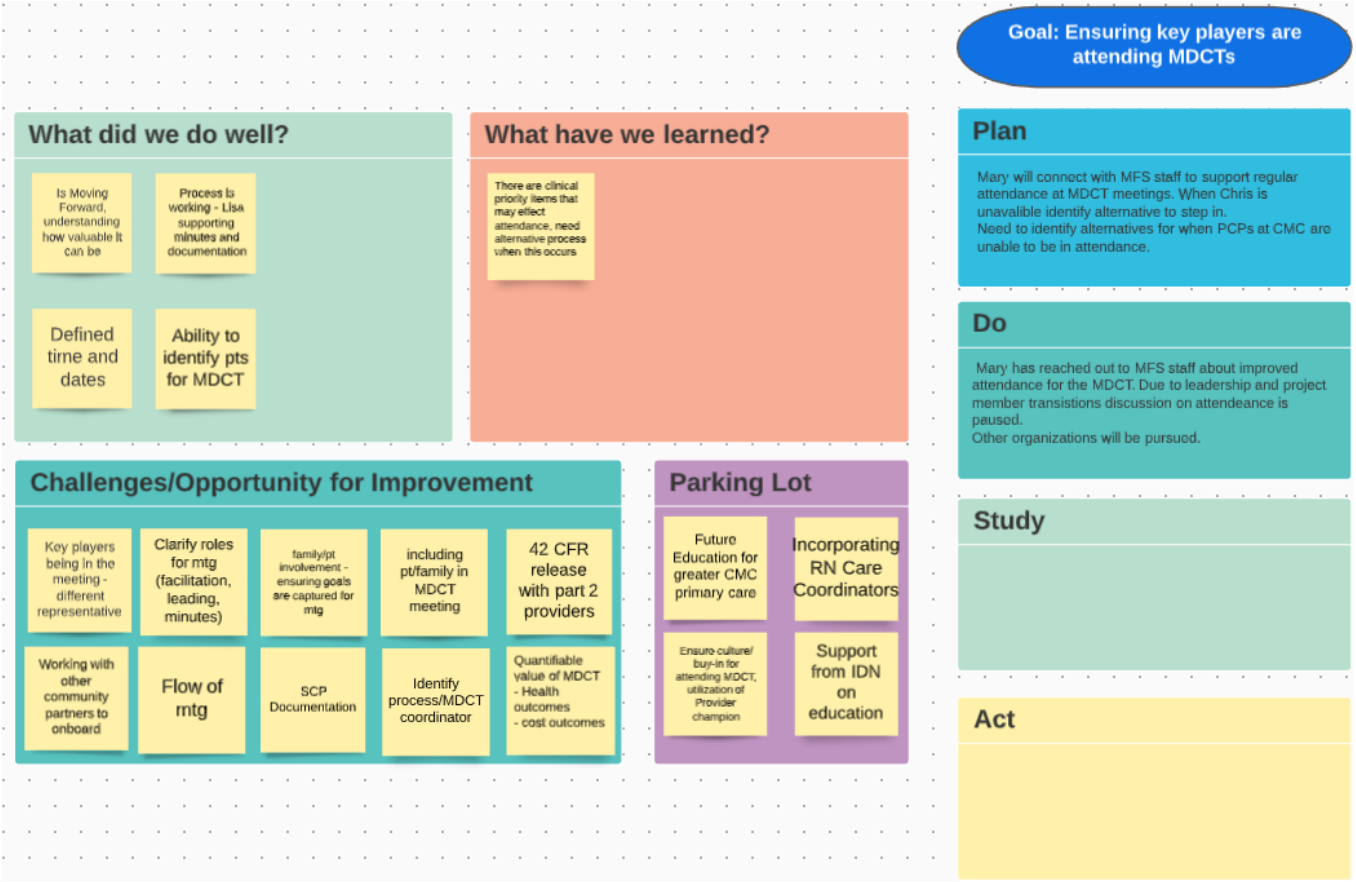


All Cheshire Primary Care B1 Implementation Progress:

Current State: July 1, 2020 – December 31, 2020

One significant change over the reporting period was the transition of the Multi-Disciplinary Care Team meetings from being held and conducted at Monadnock Family Services to Cheshire Medical Center. After further evaluation and discussion, it was determined that the meetings although valuable, could be better supported at Cheshire Medical Center. The coordination and leadership of the MDCT was taken over by one of the Behavioral Health Clinicians. Over the course of the reporting period, the team created a process, identified and engaged a primary care provider, and conducted twice monthly meetings. The process map for the MDCT and SCP can be found below. Additionally, with the patients that were first selected, they evolved to include an enhanced care team coordinator from the Co-Pilot team as they were also working with the patient. The primary care provider has found the meetings greatly valuable in better coordinating her patients care. An additional psychiatrist has engaged in the meetings and has been attending regularly. As the team has grown their MDCT, they conducted an evaluation exercise (below) in early December and planned a PDSA. In the change of the New Year however, several personnel changes at Monadnock Family Services resulted in a pause of the PDSA. The BHC plans one reengaging in the New Year. The team plans on working with other community agencies including Phoenix House.


Cheshire Medical Center
Multi-Disciplinary Care Team
10/12/2020
Pt for MDCT Identified by provider
Provider send pt information to CTC
CTC send staff message proposed new client/pt for MDCT to MFS Point Team
- Identify next apt
- Identify Care Team
CTC/MFS Point person notifies provider seeing pt next.
- Provider reviews MDCT/SCP w/ pt/client,
-completes consent,
- completes pt goals
Provider completes information for MDCT
- SCP Consent
- Pt Goals
CTC adds Pt/client to MDCT agenda
CTC send agenda for MDCT mtg prior to mtg
MDCT mtg Conducted
CTC records notes for SCP
CTC uploads SCP into CMT
Does pt/client need further MDCT Review
Determine how often pt/ client needs to be reviewed
Include pt/client on appropriate MDCT Agenda
Key
Pt. - Patient
MDCT - Multi-Disciplinary Care Team
CTC - Care Team Coordinator
MFS - Monadnock Family Services
SCP - Shared Care Plan
CMT - Collective Medical Technologies
Cheshire Medical Center
Dartmouth-Hitchcock



During the reporting period, Cheshire was able to upgrade the technology infrastructure at their two satellite clinics. With the upgrade, the clinics will now be able to utilize tablets to distribute the CCSA as well as better engage in behavioral health services. The Cheshire organization plans to allow for tele visits to the clinic and deploy the Collaborative Care integration model there as well.

The Cheshire primary care clinics continue to be challenged by the pandemic. Their clinical resources continue to be constrained and as a result they are not able to screen as much as prior to the pandemic. They continue to work on having patient's complete screening using my-DH prior to coming into their appointments. Cheshire Medical Center will as well be implementing the updated Adult Screener in replace of the CCSA they are currently using.

The bi-directional project continued to work on improvement of their model, with focus on collecting and interpreting data to show effectiveness. The project team completed the evaluation worksheet as well as the A3 (below) to showcase the accomplishments of the program and the lessons learned. At the close of the reporting period however, leadership from both organizations had determined based on the current information they have, they could not maintain a fulltime APRN position. Cheshire will look to scale the position back to part time until they are able to better financially sustain a full time position. The Cheshire administration will look to sustain the part time APRN position, the community health worker position and the behavioral health clinician position. As the team continues onto the B1 contract extensions, focus will be on improving and scaling the MDCT as well as the Adult Screener.

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Objective 4: Continuously improve client and staff experience (satisfaction and quality). **Results: Between Jan-march 2020 a client satisfaction survey was distributed to the client. 28 clients completed the survey with 95% responding either excellent/very good to "how satisfied are you with the amount of time Chris Polich spent with you", 92% rated the overall care received as excellent and 80% indicted they would most likely have done nothing if they were unable to see Chris. Staff surveys were completed during this same period of time,**

surveying MFS and CMC staff. Results reflect that MFS staff were much more knowledgeable abo the project than CMC staff, overall MFS scores were higher than CMC staff scores, and more CMC staff answered "does not apply" to questions than MFS staff. See attached slides for complete details of the staff and client survey results. In addition to this specific survey results, CMC Patient Experience result revealed several patients getting better care because of services at MFS.

Objective 5: Utilize the Region 1 shared IT platform to ensure coordinated care and communication across partners and care sites. **Results: CMT shared care plan, as of reporting date there are 46 clients in CMT however only one that has a shared care plan active. With the one shared care plan that was uploaded it was apparent that this process would be very time consuming. Several meetings with all treatment providers and client were necessary to finalize the shared care plan. The Project Manager who is also the healthcare provider was charged with leaning this process. Given his lack of experience and unfamiliarity with the platform, it also created challenges to meet requirements. It is specifically noted that uploading clients in the system and develop shared care plans that are meaningful was challenging. There has been a steep learning curve to use the system effectively for the staff uploading the data and teaching other departments at CMC to use the system.**

Objective 6: Evaluate the project so that outcomes and lessons learned can be used to justify future replication and to advocate for payment reforms that could sustain this approach to Coordinated Care Practice. **Results: Minimal attention was given to this throughout the course of the project. As we near the end, the project team is working to identify successes and lessons learned which can be found below.**

Objective 7: Improving health outcomes

- Reducing ED visits
- Reduce hypertension rates
- Reduce uncontrolled diabetes rates
- Increase screening rates: colon cancer, mammography, immunizations (flu, pneumonia, tetanus, etc.)

Results: Upon provider hiring identification of these specific metrics were established. Unfortunately due to a lack of capacity and coordination with the Informatics team at CMC the project team has not received data on these specific metrics.

IDN Project Components

- **Do you feel you successfully implemented and improved these component?**
  - **Is there further implementation/improvement to do?**
- **What barriers made it difficult to achieve or fully implement this component? What barriers will prevent sustainability (financial, leadership support, culture, staff, relationships, resources, other)?**
- **Was implementing this component valuable to how you care for patients and why?**
- **Did implementing this component enhance your professional satisfaction and relationships with coworkers, why?**
- **Are there adjustments needed to make this component more valuable? Could these components be synchronized with other organization initiatives?**
- **Are there materials missing or needing to be updated to complete the implementation (e.g., process flows, protocols, etc.)?**

There are many highlights and identification of several challenges in assessing the project over the duration. Though the project was scheduled to begin much earlier, because of the delay in hiring a provider and setting up the clinic space at the MFS building, the provider did not begin seeing patients until mid-April 2019. As with any new program,

there was a ramp up of services. See attached spreadsheet for a summary of clients serviced from April 2019 – June 2020. During this period of time, services were provided to 166 unique clients; receiving a total of 2,671 encounters.

Positives:

- **Identified intent to make services meaningful and useful to the clients – goal accomplished**
- **Clinic set up worked well, space was comfortable and inviting to clients**
- **Chris-the right person to work with the MFS clients; his approach is positive and engaging**
- **Being co-located with Genoa Pharmacy; positive working relationship with Kelly/pharmacist**
- **Access to EPIC worked well, sometimes internet connection was challenging**
- **MFS administrative support valuable**
- **Interaction between Chris and MFS clinical staff was valuable**
- **Increase accessibility for clients**
- **Monthly census use; billing for services**

Challenges/barriers:

- **Having a provider also responsible for the project management tasks did not work as planned when we put the proposal together.**
- **Provider connection and collaboration between Chris and providers at CMC, takes more time to establish working relationship since Chris was new to the system and the job**
- **Lack of clarity of role of Chris verses clinic providers: having clarity on roles responsibilities in writing in advance would have been helpful**
- **Process for getting supplies for MFS clinic site**
- **CMC Leadership changes caused delays and confusion regarding implementation of this project**
- **Intent of metrics monitoring: though we identified several key metrics, we were unable to create a registry.**
- **Should have included the CMC Informatics team in our process for identifying metrics and data collection needs.**
- **Did we utilize the staff of the IDN to help with our challenges? We could have asked them for assistance more than we did.**
-

Sustainable:

- **Unclear what the productivity expectation is for this clinic to be sustainable. Should have known this on the front end so we know what we are shooting for.**

A3 Lean Method

Project Title: Cheshire Medical Center (CMC)/Monadnock Family Services (MFS) Reverse Integration **Date: 12/15/2020**

Team: Chris Polich, Mary Buckley, Dr. Andy Trembley, Dr. Marianne Marsh, Eileen Fernandes, Shawn LaFrance

Project Background

Prior to the start of this project there were no systematic workflows to optimize effective communication and collaboration around shared patients of MFS/CMC Primary Care. Lack of communication and coordination may lead to poor patient health outcomes, increased ER visits, increased hospitalizations, and patient not receiving needed services. The purpose of the project is to improve clinical outcomes for patients receiving services from both MFS and CMC through better access to medical services provided by CMC, improve CMC and MFS communication through a multidisciplinary team approach to services, and increase care coordination.

Current Conditions

Prior to project implementation, many MFS clients did not attend to their health care needs, avoided seeing a primary care provider at Cheshire Medical Center or the patient's services at CMC were terminated due to disruptive behavioral issues.

Goals/Objectives

1. Create, test and refine a co-located "reverse integration" Health Home Model.
2. Assure that every individual has a comprehensive plan of care
3. Assist individuals with acquiring skills for managing their chronic
4. Continuously improve client and staff experience (satisfaction and quality).
5. Utilize the Region 1 shared IT platform
6. Improve health outcomes

Analysis

Developing and implementing established work flows has been an initial barrier to coordinating care for shared MFS/CMC Primary Care patients. Data and analysis of patient's medical services provided and effective communication between APRN at MFS and the patient's PCP at CMC has been challenging. This positive communication/collaboration is essential to the project success moving forward.

Plan the Improvement

Revise job description for APRN to clarify responsibilities and determine amount of time needed for clinical services. Develop a join CMC and MFS joint agreement in 2021 with protocols and procedures for staff involved in the care of patients served through this project. Establish joint measures with reporting and analysis to assess the effectiveness of the project. Establish monthly project meetings with CMC and MFS leadership to discuss performance measures and monitor sustained improvements.

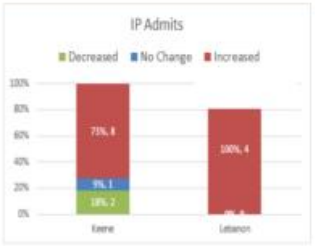
Do the Improvement

Staff were hired at CMC and MFS for project
Patient consent process was established
MDCT process initiated using CMT
Review accomplishments and challenges encountered (2019-12/2020)
Implement Plan for Improvement in 2021

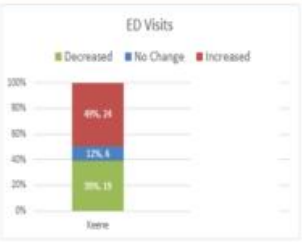
Check the Results

Tracked the number of encounters and unduplicated clients seen in the clinic

Act & Determine Next Steps



Analysis IP admit and ED visits for clients in program



B1 Newport Health Center (NHC) Coordinated Care Project Updates

Project Overview

- The Newport Health Center Pediatrics team launched officially in early summer, 2018 with a small core team supported by the site MSW, Administrative support and Pediatrician.
- After meeting the coordinated care designation requirements for the pediatric practice, Newport Health Center completed the spread of to all adult providers in the summer of 2019.

Current State: July 1, 2020 – December 31, 2020

During the reporting period, the project team continued to face impacts related to pandemic response. Additionally, the organization underwent an electronic health record conversion to Epic to better integrate with the Dartmouth Hitchcock Medical Center system. This transition paused project work for about a month. The team met once every two weeks and the larger team met once a month. Additionally, the team continued to hold a once monthly Multi-Disciplinary care team meeting. One MDCT case in particular saw eight partners at the table to support the coordination of care for a pediatric patient. The team reported that this experience was not only valuable for the patient's needs (patient was included in the MDCT) but it supported the building of relationships between organizations.
During the period the project team completed a "playbook" which is a compilation of all their work as well as an A3. Both documents are below, however due to the length of the playbook (119 pages) only the table of contents are provided. Two tables which have been pulled out below from the A3 include comparison charts based on CCSA data for 2019 and 2020. The first data looking at the youth assessment and the mental behavioral health screens shows increased rate for all in 2020. In the second table which compares social determinants of health and mental/behavioral health results for the adult screen shows a decrease across assessment answers. Similar results were reported when comparing to Valley Regional Hospitals data. Uncertain of the causation, the IDN administration team is looking closer at the raw data.

In February, 2021 the New London Hospital team notified the IDN leadership that given ongoing staffing constraints and conflicting internal organization priorities they would be unable to continue with IDN1 funded B1 project work in CY2021.

Newport Health Center

IDN B1 Integration

Table of Contents

A3 Lean Method

Project Title: B1-NHC Project **Date: 12/16/2020**

Team: Erin Angley, Trina Dawson, Rebecca Lozman-Oxman, Cecily Fellows, Rebecca Fellows, Nicole Poudrette and Elizabeth Sweeney

Project Background

Collaboration between primary care and mental health providers has shown to improve outcomes for patients. A good partnership with the whole treatment team results in better adherence to the overall treatment plan including medication compliance; consistently showing for appointments and following through with goals. This project sought to bring together primary care programs and mental health/counseling programs which have been historically separate entities to share treatment plans, coordinate care and discuss progress or setbacks to promote success for the patient.

Current Conditions

STAFFING:
- One social worker
- One psychiatrist

CO-LOCATED
- Unaffiliated, counseling agency

Survey to Identify Greatest Hurdles & Staff Anxiety:
* Gaining provider "buy-in"
* Creating & following through with workflows established with outside providers
* How will we get everyone on the same page, doing the same thing?
* Identifying eligible patients and their completion of CCSA

Goals/Objectives & Analysis

QUARTER ONE	Milestone #1		**Comprehensive Core Standardized Assessment (CCSA) *aka Patient Questionnaire***
		1A:	Identify and approve CCSA tools
		1B:	Create pathways to address CCSA questions for each patient type
		1C:	Process mapping update for future state & CHW inclusion
		1D:	Launch pediatric CCSA to R. Lozman-Oxman's patients: **nonacute visits only**
		1E:	Training on purpose and use of Plan, Do, Study, Act (PDSA) cycles
		1F:	Complete PDSA cycles on CCSA workflow and identify gaps; role of MSW & CHW
	Milestone #2		**Multi-Disciplinary Care Team (MDCT) *aka Provider Meetings***
		2A:	Review and approve Special Consent for Pediatrics
		2B:	Create and approve procedures for MDCT
		2C:	Training and scheduling of MDCT and trial run with agenda and mental health providers
		2D:	Complete PDSA cycle of MDCT and identify gaps
		2E:	Training on use of Shared Care Plan
Q-2	Milestone M. #3		**Expansion of Initiative to Primary Care Providers**
		3A:	Introductory Luncheon Presentation to all primary care providers and staff; Monday, April 1st
		3B:	Expand project to **nonacute, annual visit adult patients** served by all providers
		3C:	Identify role of on-staff psychiatrist in program
Q-3	M. #4		**Evaluate Quality Reporting and Program**
		4A:	Evaluate quality reporting requirements for all components
		4B:	Analyze staffing impact and delivery of model on patient care; efficiencies
		4C:	Create process integration plan for on-site psychiatrist
Q-4	M. #5		**Sustainability**
		5A:	Confirm adult patients and well-child pediatrics involved in program, all practices, all providers
		5B:	Confirm successful integration of on-site psychiatrist in program
		5C:	Complete PDSA cycle for 3C

regi n1 — PARTNERSHIP FOR INTEGRATED CARE — UPPER VALLEY SULLIVAN COUNTY MONADNOCK REGION

Plan the Improvement

All Staff/All Provider Trainings

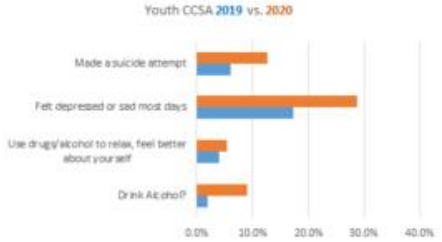
Letter to All Patients

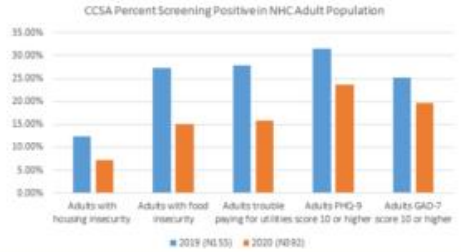
Identify Current State & Future State Workflows

Do the Improvement

- Welcomed Community Health Worker & integrated person into patient care system
- Established 2x/month project meetings & secured outside project coordinator/facilitator
- Designed MDCT/SCP Process & Consent Forms; Established successful communications flow with Counseling Associates
- Created (3) SDoH Patient Assessment Forms, Positive Response Pathways & Data Entry Registry

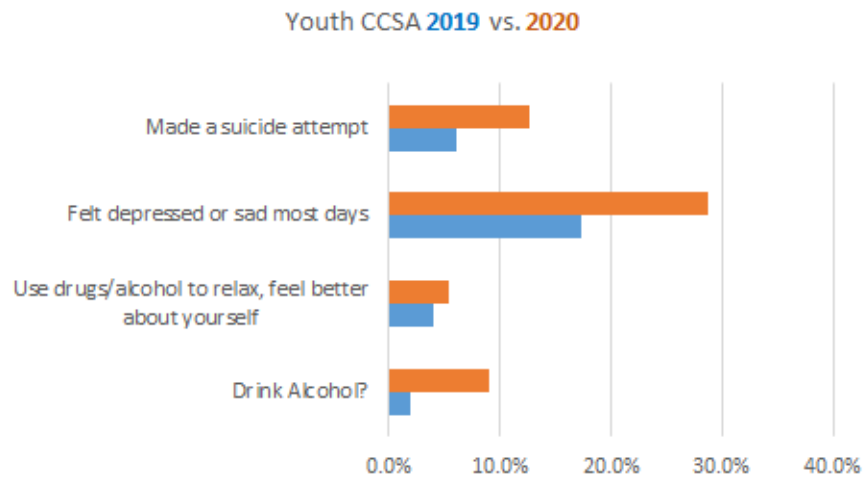
Check the Results

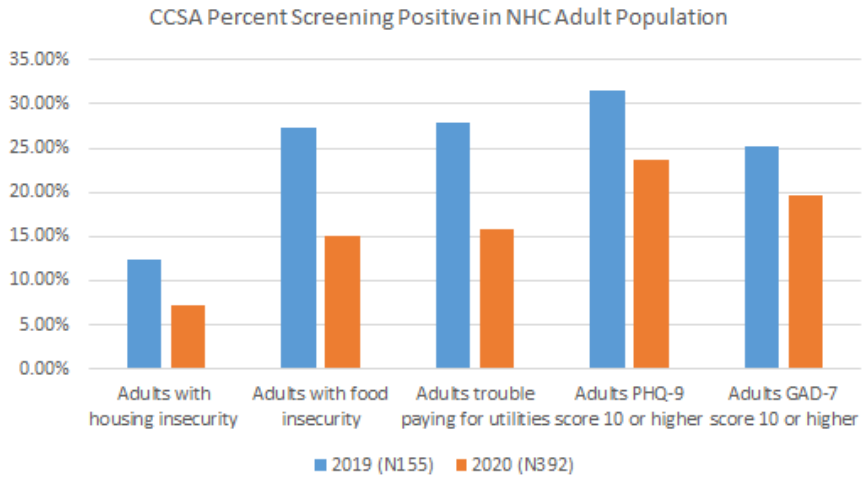




Act & Determine Next Steps

- Transition to tablet-based assessment collection & EPIC reporting format
- Improve collaboration opportunities with WCBH
- Redesign workflow w/o Community Health Worker





The Newport Health project team continued to collect CCSA data within their registry. This contributed to the tables above based on the data tables below. As the team finishes transitioning to Epic, they will have the ability to transition from paper CCSAs to the Adult screener via a tables. The transition will allow them to capture the data within the EHR system, eliminating the extra personnel time recoding the data into a registry.

The clinic is looking to transition to the new screener in the beginning of the New Year. Unfortunately the community health worker located at Newport Health Center transitioned jobs, and the hospital has not yet determined if they will be able to financially sustain the position after IDN funding ends.

B1 Monadnock Community Hospital (MCH) Updates

Project Overview

- The MCH project team began meeting in early summer, 2018.
- In early spring of 2019, the team experienced several leadership changes resulting in a stall of forward movement. In late spring the team reconvened under new leadership with the addition of primary care team staff from both implementation sites of Jaffrey and Ridge clinics. The team has since included a third satellite site, New Ipswich.

Current State: July 1, 2020 – December 31, 2020

The Monadnock team entered the reporting period with establishing a new project team after losing much of the previous project team either to personnel being furloughed or resigning. While the team regularly met for once monthly meetings, progress on any of the core requirements for the IDN work struggled greatly. The team was able to redeploy the paper CCSA in one outpatient clinic, however they met several challenges in consistently deploying it. Additionally, they were unable to continue to have MDCTs on a monthly bases.

The team had ongoing conversations when they met about opportunities to improve their behavioral health integration efforts within the satellite clinics. They reviewed several models and leadership reached out to other regional partners. The team now has future goals, when they are able to refocus their efforts. As one of the ongoing challenges for Monadnock was lack of staffing, they did move forward in building a relationship with the University of New Hampshire's Master of Social Work internship program at this time. Their goal continues to be that through taking on interns they are hoping that they will be able to attract more clinical talent to the organization.

Given the significant impacts to the organization as the IDN administrative team engaged in meetings throughout the fall around continued project work in CY2021 the tough decision was made by the executive leadership at Monadnock Community Hospital that they simply did not have the bandwidth or the appropriate staffing in place to continue with project work. Over a series of meetings the IDN leadership team worked on close out activities with the team at MCH and formally disengaged with the project in December, 2020. MCH remains an IDN partner and we hope

that once the organization is able to stabilize their staffing and funding impacts due to the pandemic that they will resume some of the behavioral health integration work they had undertaken during the IDN program.

B1 Alice Peck Day Memorial Hospital Primary Care Coordinated Care Project Updates

Project Overview

- The team began meeting bi-weekly in the early fall of 2018.
- In May of 2019 the APD team underwent a system wide EHR conversion, onboarding to the DHMC Epic platform. Progress on their work to implement the CCSA and other CCD components were slow until they were able to go through the event.
- The team proposed to follow the AIMS center collaborative care model and after careful consideration moved to adoption of the full DH CCSA in EPIC in June, 2019

Current State: July 1, 2020 – December 31, 2020

The Alice Peck Day team continued to focus on sustainability efforts while also working on evaluation of their B1 work thus far. Having committed early to sustaining their behavioral health clinician, the B1 extension dollars will help to support bringing on an additional BHC in the New Year. The team continues to feel the strain in their clinic due to the pandemic, and have several positions open leading to other roles having to fill in. This has impacted how many resources they can devote to meetings and how often they are able to all meet with the IDN administration, however they were able to keep us regularly updated while continuing to work on internal improvement. Alice Peck Day will be implementing the Adult Screener's developed by the Dartmouth health system partners, with representation during the content creation from the APD team. The implementation is schedule for the beginning of the New Year. Additionally, the team maintain MDCT meetings, primarily meeting with representatives from West Central Behavioral Health. Due to their resource constraint, they have been unable to scale to other external partners and additional patients.

The team over the course of the reporting period additionally completed the worksheet evaluation and A3 (below). The teams continued goal is to fully implement the Collaborative Care model, and with new developments within the Dartmouth system of resource onboarding, the team expect to be able to move forward with that goal. Additionally, the team has always appreciated the resource of the Integrated Delivery Network, and is an ongoing advocate for how to continuously maintain the open dialog and shared learning across health care organizations in the region. The APD team plans to continue with the IDN work through the B1 2021 contract extension.

Goals

- What were your original goals and expectations for the project?
- Has your perception of the project changed over time and did your goals change as a result?
- What goals were met/unmet (speak to goals which have progressed but have not fully been met)?
- Do you have new or additional goals in achieving further integration?
- Where/are your goals supported across your organization (clinicians, support staff, financial, management)?

APD's original goals and expectations for the project were to accomplish the planned project objectives (hire BHC, implement CCSA, screen patients, and initiate MDCT meetings). While these objectives were met, the organizational task of implementing a new electronic health record, an intentional delay in implementation of the CCSA screener until a BHC resource was hired, a small cohort of patients, and the onset of a public health crisis have been barriers in achieving an integrated clinic that meets the project team's expectations. "We're doing it, but we have more to do".

New goals: optimization of the CCSA screener, including additional SDOH questions, and spreading across all patient populations at APD.

IDN Project Components

- Do you feel you successfully implemented and improved these component?
  - Is there further implementation/improvement to do?
- What barriers made it difficult to achieve or fully implement this component? What barriers will prevent sustainability (financial, leadership support, culture, staff, relationships, resources, other)?
- Was implementing this component valuable to how you care for patients and why?
- Did implementing this component enhance your professional satisfaction and relationships with coworkers, why?
- Are there adjustments needed to make this component more valuable? Could these components be synchronized with other organization initiatives?
- Are there materials missing or needing to be updated to complete the implementation (e.g., process flows, protocols, etc.)?

CCSA	CCSA was successfully implemented, but there are areas of improvement within the clinic and at a system level that are currently being addressed.

MDCT	MDCT was successfully implemented, but improvements are needed: 1. There are some participating agencies are not involved that would be beneficial to the team if they attended. 2. Work towards a structured meeting for the MDCT's rather than general check-ins. 3. Reinforcement with our (APD's) providers of the need for them to be involved.
SCP	SCP was implemented, but as it is outside of the current EMR, it has been burdensome. Updating the Shared Care Plan can be time consuming and without admin support, reduces BHC clinical availability. Our experiences are that others are not regularly using or referencing the SCP. Additionally, we have found that it is very rare that our patients are going to a hospital that isn't on our EMR (Valley Regional).
Integration Workflow	CCSA has allowed flow staff to ask the questions that need to be asked. Due to the current public health crisis, there have been gaps where the CCSA wasn't reviewed or completed (patient refused tablet, refused questionnaire in exam room). Future areas of improvement would be to better define interventions/counseling for utilization.

Project Process

- What went well?
- Were there project or change management pieces missing which would have better supported meeting the goals?
- Is there anything you would have done differently?

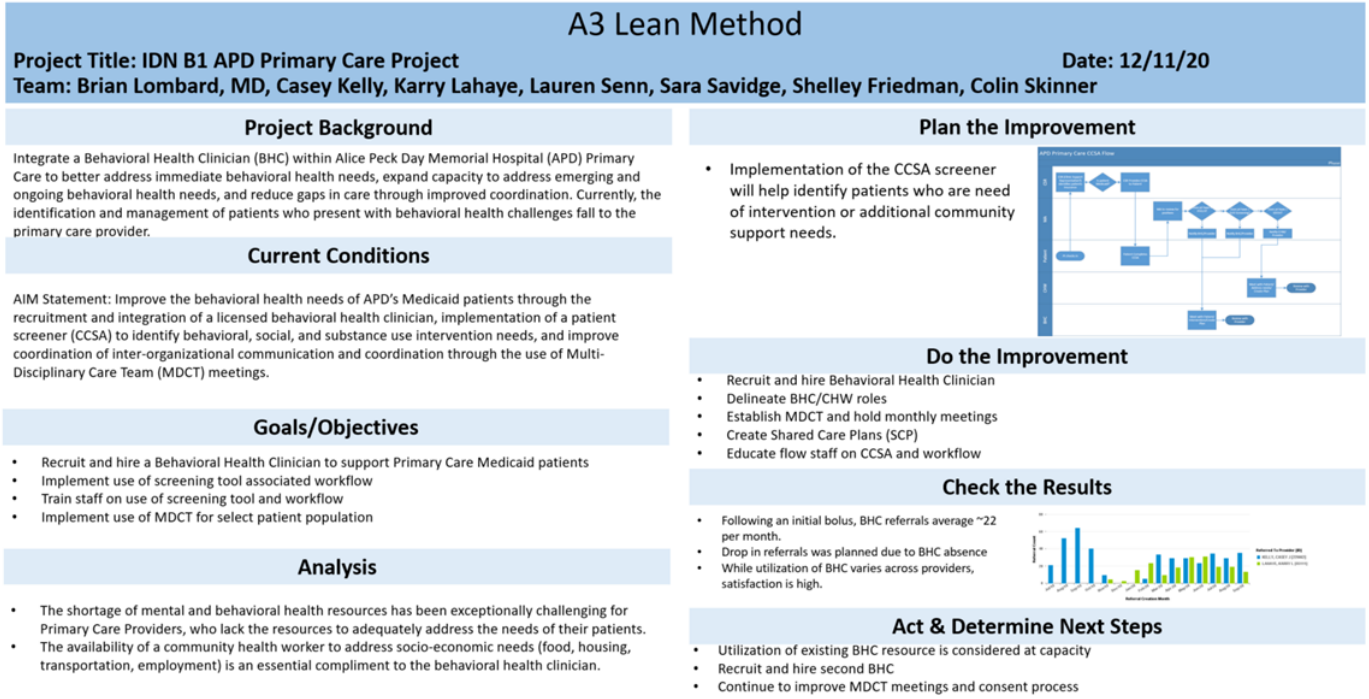
Project Planning	It was very helpful to have the external resources from IDN to assist with project management and timeline management.
Project Implementation	Much of the work hinged on the recruitment of a behavioral health counselor; it was difficult to make gains until the resource was hired. Additionally, resources were limited in order to support a new EHR implementation, the required training, and post go-live optimization
Project Improvement	Because the population was limited to Medicaid (i.e. small weekly volume), and also disruption of a public health crisis, improvement efforts were limited.

Transition Planning

- Are there actions/resources you need from the IDN administration for transitioning?

- Are there actions/resources you need from your regional partners before transitioning (healthcare provider, behavioral health provider, community support agency, other)?
- Are there actions/resources you need on a state level before transitioning (DHHS, other IDNS, other)?

The greatest concern with the closing of the IDN project is the incentive and reinforcement for other agencies to prioritize engagement and collaboration. Mechanisms that allows for prioritization (local forum, system prioritization, etc.) are needed.



A3 Lean Method

Project Title: IDN B1 APD Primary Care Project **Date: 12/11/20**

Team: Brian Lombard, MD, Casey Kelly, Karry Lahaye, Lauren Senn, Sara Savidge, Shelley Friedman, Colin Skinner

Project Background

Integrate a Behavioral Health Clinician (BHC) within Alice Peck Day Memorial Hospital (APD) Primary Care to better address immediate behavioral health needs, expand capacity to address emerging and ongoing behavioral health needs, and reduce gaps in care through improved coordination. Currently, the identification and management of patients who present with behavioral health challenges fall to the primary care provider.

Current Conditions

AIM Statement: Improve the behavioral health needs of APD's Medicaid patients through the recruitment and integration of a licensed behavioral health clinician, implementation of a patient screener (CCSA) to identify behavioral, social, and substance use intervention needs, and improve coordination of inter-organizational communication and coordination through the use of Multi-Disciplinary Care Team (MDCT) meetings.

Goals/Objectives

- Recruit and hire a Behavioral Health Clinician to support Primary Care Medicaid patients
- Implement use of screening tool associated workflow
- Train staff on use of screening tool and workflow
- Implement use of MDCT for select patient population

Analysis

- The shortage of mental and behavioral health resources has been exceptionally challenging for Primary Care Providers, who lack the resources to adequately address the needs of their patients.
- The availability of a community health worker to address socio-economic needs (food, housing, transportation, employment) is an essential compliment to the behavioral health clinician.

Plan the Improvement

- Implementation of the CCSA screener will help identify patients who are need of intervention or additional community support needs.

Do the Improvement

- Recruit and hire Behavioral Health Clinician
- Delineate BHC/CHW roles
- Establish MDCT and hold monthly meetings
- Create Shared Care Plans (SCP)
- Educate flow staff on CCSA and workflow

Check the Results

- Following an initial bolus, BHC referrals average ~22 per month.
- Drop in referrals was planned due to BHC absence
- While utilization of BHC varies across providers, satisfaction is high.

Act & Determine Next Steps

- Utilization of existing BHC resource is considered at capacity
- Recruit and hire second BHC
- Continue to improve MDCT meetings and consent process

B1 Support Partners:

Phoenix House

The IDN1 admin team met with Phoenix House (Keene), which provides outpatient and inpatient SUD treatment services, leadership in June, 2018 to address coordination with the B1 project. Given limited numbers of Medicaid members seen, and the spread of patients across the Keene and Dublin sites, the IDN1 admin team is having ongoing conversations in how the organizations can support the B1 teams in the region. Phoenix House is already aligned with MFS/CMC on a HRSA SUD grant, so it will be directly involved as a support for the B1 work as well and the CMC team will look to onboard them to the MDCT in the new year. Phoenix House will continue to be an active partner in the Keene region but will not be formally funded under the B1 program in CY2021 due to IDN administration budget restrictions.

Counseling Associates (CA)

Counseling Associates began their B1 support with a contractual relationship with VRH. With the growth of the regional B1 project work and need for behavioral health access, the IDN administration restructured their contracts to directly fund Counseling Associates for B1 support to multiple primary care agencies, therefore removing them as a subcontractor of VRH. The IDN held a support contract directly with Counseling Associates running through 12/31/20 and will continue into 2021 with the B1 contract extension. Counseling associates is now actively involved with Valley Region Hospital, Newport Health Center, and Alice Peck Day. The organization has been actively deploying the CCSA for a couple of years. Counseling Associates staff have also been active members of the E5 Sullivan County Complex Care team having presented several de-identified cases. During COVID-19 quarantine the organization restructured appointments to telehealth only however maintained active communication with all B1 sites in ensuring continuity of patient care.

West Central Behavioral Health (WCBH)

West Central Behavioral Health originally started their work in partnership with the DHMC Heater Rd. team. Similar to CA's expansion of services, WCBH quickly began partnerships with other B1 teams to better support the coordination of care and access with behavioral health services. As result, WCBH became another B1 supporting contract receiving funding for increase capacity to serve the B1 teams. They will continue with the contract into 2021 with the contract extensions. WCBH now sits at the MDCT tables for Valley Regional Hospital, Newport Health Center, Alice Peck Day and all three Dartmouth Hitchcock teams. WCBH has met the requirements for distributing the CCSA for a couple of years. Staff of WCBH have also been a regular member of the E5 Sullivan County Complex Care Team, having presented several de-identified cases. COVID-19 response caused the organization to move much of their services to telehealth, however due to limited technology had challenges with access to care. The organization continued to meet with some clients in person and out in the community. They currently are challenged with staffing shortages and the ability to increase services to new referrals. WCBH has opened the center back up for in person visits while also providing telehealth visits.

Monadnock Family Services (MFS)

Monadnock Family services has been an active participant of the bi-directional B1 project in which a CMC APRN is embedded in their clinic to provide medical services to their patients. In addition, they are provided a B1 support contract in order to build capacity in meeting the behavioral health needs of the area. MFS has implemented the CCSA. As part of their agency pandemic response, MFS moved visits where appropriate to telehealth, providing in person visits to clients only when absolutely necessary such as for metabolic monitoring with psychotropic medication. The center has since open backed to in person visits while still supporting those who choose telehealth. MFS will be continuing with the IDN with the B1 contract extensions.

Headrest

Headrest has been an active participant with the IDN and B1 projects since the beginning of project implementation. They have had a close relationship with Alice Peck Day due to being located on the same campus. This has allowed then to work collaboratively on shared patients. Headrest leadership is actively working with the DHMC system to become a more active part of their MDCT meetings. The largest challenges has been ensuring their processes is compliant with 42CFR. Headrest will continue to be an active partner in the Lebanon region but will not be formally funded under the B1 program in CY2021 due to IDN administration budget restrictions.

Budget

Provide a narrative and a brief project budget outlining actual expenditures and projected costs to support the community project which must include financial reporting.

The budget table below is broken out by calendar year and the contracts have been staggered to reflect their end date and total spent vs. originally contracted. This new method of presenting the budget information simplifies the totals by project as they are tracked by grant year as well as contract year and now presents only the original contracted amount and the total invoiced.
The final budget for each partner is refined through an iterative process as the IDN admin team balances attribution, available funds and helps each organization finalize its B1 scope of work and customize to the local environment. IDN 1 also offer incentives to the Community Mental Health Centers and smaller Behavioral Health providers to participate in the local B1 projects including confirming position to receive referral, facilitating engagement on the MCDT and submitting required data for reporting.

The budget table below includes total awards by organization site for the remaining year of project implementation expenditures through 2021 by CY. *Of note- as many of the B1 partners had a carryover amount of funds unexpended in the CY2019-2020 contract those funds have been incorporated in the 2021 award.

DHMC Lebanon System Budget:The IDN 1 administration previously support the DHMC Lebanon system on a per project basis. In July of 2019 with the contracting period, IDN 1 administration and DHMC Leadership agreed on a system level budget to better allocate positions for sustainability and to ensure a more efficient approach to tracking and use of funds. The table below reflects actuals for CY2020 that had previously not been reported in the July 31st SAR as the Jan-Jun, 2020 period had not closed at the time of submission. The total for the time periods reflects actual expenditures and the total award for CY2021.

Valley Regional Hospital:

Valley Regional Hospital will enter the new 2021 contact year with a total award of $[redacted]. The funding for the new CY2021 contract is entirely carryover funds from the CY2019-CY2020 project contract that the VRH team did not expend.

CMC/MFS & CMC System: During the contracting period of July 1, 2019 through December 31, 2020 the addition of the IDN work with in CMC primary care greatly expanded. As a result the CMC budget now includes CMC primary care as well as the CMC/MFS bi-directional project budget. This approach allows for better tracking from a system perspective in allocating positions and resources. The table below reflects actuals for CY2020 that had previously not been reported in the July 31st SAR as the Jan-Jun, 2020 period had not closed at the time of submission. The total for the time periods reflects actual expenditures and the total award for CY2021.

Monadnock Community Hospital (MCH):

During the period, Monadnock Community Hospital (MCH) continued to experience low personnel resources as reflected in the budget (salary line includes benefits) line items. Additionally, with the decrease in data reporting needs they underspent in the data and IT support line. MCH will not be continuing into the 2021 year and will be paying back unspent dollars in the amount of $39,076.86 to the IDN which have been reallocated for organizations continuing into the new contract year.

Alice Peck Day (APD):

Alice Peck Day will enter the new 2021 contact year with a total award of $[redacted]. The team has a carryover of CY2019-2020 contract funds in the amount of $[redacted] that is included in the new total award.

New London Hospital/Newport Health Center

NLH will not be participating in the IDN project work in CY2021. They are paid in full for their 2020 contract.

REDACTED TABLE

B1-10. IDN Integrated Healthcare Project: Achievement of Coordinated Care Practice and Integrated Care Practice Designation

Use the format below to identify the total number of practices/providers who have **achieved** designation as a Coordinated Care Practice or Integrated Care Practice. IDNs are expected to make continual progress toward achieving their projected number of designated Coordinated Care Practices and Integrated Care Practices.

Achieved	Total Goal Number Designated	Baseline Designated 12/31/18	Number Designated 6/30/19	Number Designated 12/31/19	Number Designated 6/30/20	Number Designation 12/31/20
Coordinated Care Practice	10	3	5	11	11	11
Integrated Care Practice	4	3	3	5	5	5

Projects C: Care Transitions-Focused

Narrative

Provide a detailed narrative which describes the progress made during this reporting period.

During the reporting period, the program team met regularly both with and without the IDN team. The internal team meets multiple times weekly to address clinical and ongoing process improvements. With IDN support the team met intending to provide shared learning and training. During these meetings, the team addressed ongoing challenges and opportunities for improvements. Much of the focus of the Co-Pilot team was navigating the necessary adaptations to delivering case management during the second wave of COVID-19. Half of the team worked remotely and switched to more phone based communication with clients which brought new challenges. The case managers reported ongoing challenges and offered shared solutions to getting back signed paperwork, connecting with socially isolated clients and many others.

The IDN administration met with senior leadership about once monthly to discuss sustainability and evaluation of project work. Both organizations that hold funded staff are committed to sustaining all positions both within the Enhanced Care Coordination and Critical Time Intervention programs. They are looking at several resources for financial sustainability and will plan to roll the positions into new and ongoing work within each of the organizations. As the team continues to focus their efforts on sustainability, they are continuing to find new opportunities to allocate data that can showcase the effectiveness of the program. The three participating organizations (The Monadnock Collaborative, Monadnock Family Services, and Cheshire Medical Center) will continue to work together using program data to support the ongoing work. The administration began to shift their vision early in the reporting period from the silo of the project work, to expansion into the larger system. With the implementation of the "No Wrong Door" and "Care Pathway" work, they are looking to streamline efforts and eliminate redundancy. In early November, the Co-Pilot team and IDN administration met to review the Evaluation Worksheet (below) and further debrief on the past few years of work. The

comments included in the evaluation worksheet below are taken from members of the project on both sides of the clinical program and leadership of the affiliated organizations.

The Co-Pilot IDN project concluded its project work with the IDN at the close of December, 2020. While they will not be an ongoing part of the IDN into 2021, they will continue the Co-Pilot work they have established.

Goals

- What were your original goals and expectations for the project?
- Has your perception of the project changed over time and did your goals changed as a result?
- What goals were met/unmet (speak to goals that have progressed but have not fully been met)?
- Do you have new or additional goals for this work?
- Where/are your goals supported across your organization (clinicians, support staff, financial, management)?

According to the team charter written 10/12/2017 the goals of the project are:

1. Streamline access to services, reduce ER readmissions, improved quality of life for patients, and improved individual and population-level health indicators, Social Determinants of health are routinely addressed along with medical care in an integrated way, improvements in the management of chronic health conditions. **Results: Effectively developed system for quick referral and assignment process.**

2. Reduce the number of poor mental health days amongst adults from 3.8 in 2015 to 2.8 in 2019.
   a. Decrease in client self-reported poor mental health days: **Results: Data collected via survey (pulled info from quarterly report 1/21/19): 11 of the 13 clients report a monthly decrease (averaged number) in the number of poor mental health days between the month prior to starting Copilot and the time while they have been involved in Copilot.**
   b. Increase in number of social interactions per week: **Results: Data collected via survey (pulled info from quarterly report 1/21/19): 6 of 13 clients report that that they have not become more involved in the community since starting Copilot; 7 of 13 clients report that they have become more involved in the community since starting Copilot.**
   c. Increase in participation in any groups (social religious, self-help, public service, etc.): **Results: Data collected via survey (pulled info from quarterly report 1/21/19: 7 of the 18 replied that the Copilot Program has helped them to become more involved in their community; 11 of 18 replied that they neither agree nor disagree that the Copilot Program has helped them become more involved in the community.**

3. Reduce overall homelessness in Cheshire county from 96 in 2016 to 86
    a. Increase in number of people placed in housing: **Results: 5 of 30 copilot clients were homeless at the time of referral (pulled info from quarterly report 1/21/19). The 5 individuals homeless at time of entry are now housed. This is an increase in the number of program participants housed.**
    b. Increase in number of people working with housing services: **Results: An increase of 5 individuals engaged with housing services (pulled info from quarterly report 1/21/19)**
    c. Decrease in consecutive days without shelter: **Results: 5 clients were homeless at the time of referral. All clients are sheltered, 2 clients remain without permanent domiciles (pulled info from quarterly report 1/21/19). The 5 individuals homeless at time of entry are now housed. This is an increase in the number of program participants housed.**
4. Reduce Social Isolation
    a. Increase the number of social engagements: **Results: 6 of 13 clients report that that they have not become more involved in the community since starting Copilot; 7 of 13 clients report that they have become more involved in the community since starting Copilot. data collected via survey (pulled info from quarterly report 1/21/19)**
    b. Increase the number of referrals accepted for services and social resources in the community: **Results: We are not currently tracking this data. The team post charter development assessed that this was not a time-worthy data point to continuously track.**

IDN Project Components

- Do you feel you successfully implemented and improved the component?
    - Is there further implementation/improvement to do?
- What barriers made it difficult to achieve or fully implement this component? What barriers will prevent sustainability (financial, leadership support, culture, staff, relationships, resources, other)?
- Was implementing this component valuable to how you care for patients and why?
- Did implementing this component enhance your professional satisfaction and relationships with coworkers, why?
- Are there adjustments needed to make this component more valuable? Could these components be synchronized with other organization initiatives?
- Are there materials missing or needing to be updated to complete the implementation (e.g., process flows, protocols, etc.)?

Successes:

- Leveraging of short-term, intensive care coordination of role of ServiceLink AND clinical case management and consultation of MFS
- Tracking of supportive processes needed to connect to ongoing services
- Development of procedures, protocols and flow maps
- Client satisfaction survey administered twice (attach results from first survey in 2019)
- System for tracking referrals to CoPilot
- Training plan developed at start of implementation (saw list in the quarterly 1/21/19)
- Use of PDSA for team leader role, housing & participant experience
- Development of Copilot Wellness Assessment scale (is also a challenge as Eileen did not know of this tool – wondering who is using it.)
- Following the CTI phases worked best; pre CTI and phase 1 was critical to establishing relationship with clients; with Phase 2 and 3 you could see clients self-advocating; just needed someone to walk thru the systems with them.
- Using the framework of CTI for time limited services, worked well with ECC. Clients were more invested when they understood there was a time limit.
- Got clients who were seen as "difficult" using the model of CTI and ECC helped to establish bridges with other agencies.
- CTI phases really helpful
- Smaller caseloads; weighted caseloads was helpful- provided framework of time/energy per client
- CMC very open to working with ServiceLink; foundation in place between CMC and ServiceLink allowed for an easier implementation of CTI.
- Mixed caseloads allow for adaptability of our roles and skills
- Building bridges with medical providers for individuals with mental health needs
- ECC embedded in MFS has improved coordination with other MFS providers
- Supporting clients who had a negative experience with an agency in the past; working with them to work through this to see positive opportunity to the future. + and - CoPilot staff offered opportunity for client to grow from this experience
- Because Copilot was trying to break down silos of services, we saw the value of having CoPilot to break thru this.

Challenges/Barriers:

- Maintaining clarity between distinct goals of CTI versus ECC
- Identifying differences between traditional case management , care coordination and ECC
- Mixed caseload of both CTI and ECC was challenging, felt that they were being a case manager rather than the specialty framework for copilot
- CTI focus on transition from hospital to community; ECC not the case- so with a caseload of both CTI and ECC it was difficult for the staff.
- Continued need to work on relationships with key partners for referrals.
- COVID- added challenge for staff to go to CMC, impacted part of the CTI model to see clients in the hospital before discharge. CMC set up a "virtual introduction" however have not used it effectively. CoPilot Team meetings scheduled with training components ended. Seeing clients in person, not able to provide transportation, home visits all ended. Difficult to assess clients when you are talking on the phone or with zoom. Had to stop meetings at social service organization, getting clients connected to other agencies.
- Sometimes the blurring of roles and moving more into traditional case management happens
- Sometimes there is the possibility of duplication, especially for ECC working with clients who have MFS Case Managers.
- Role delineation – it is easy for overlap to happen when there are multiple people offering assistance to a client
- CTI had difficulty working with MFS staff – concern noted for duplication of services
- CTI- difficulty securing services for clients who needed MFS services
- One team in two different locations – made it difficult to consult with each other for guidance
- Collaboration with other agency was challenging; some wanted to "do their own thing" hard to bring everyone together to identify what each provides and how they can work together.
- Supporting clients who had a negative experience with an agency in the past; working with them to work through this to see positive opportunity to the future. + and –
- Don't underestimate the amount of time it takes from an administrative function for two organizations to collaborate.
- Do you have the right "decision makers" involved in the planning and beginning implementation

Barriers to sustainability:

- Funding for the services that billing Medicaid is not an option (CTI and ECC for individuals that do not meet criteria for state supported services through MFS)
- Possible solution: Jen oversees Medicaid administrative dollars in our region; which may be a way to continue CTI beyond the IDN grant

Project Process - What went well? - Was there project or change management pieces missing which would have better-supported meeting the goals? - Is there anything you would have done differently?	
Project Planning	Significant time devoted to planning initially as well as during the project to adapt our processes and improve coordination and communication between the partners.
Project Implementation	Initially ECC and CTI staff had a blended case load, this proved to be challenging for the staff and CTI had very prescribed steps and ECC did not. Decision made to have staff either be CTI or ECC made for better clarity for the staff
Project Improvement	It is very difficult to have partner organizations collaborating if there is not clearly defined roles and responsibilities of each organization clearly described up front. This lack of clarity caused confusion and frustration for all.

Additionally, as part of their "wrap up" work, the team completed an A3 to showcase their work over the past 4 years. (A3: a lean quality improvement tool). They participated in the December IDN Knowledge Exchange where they presented their final draft and spoke about the program to regional colleagues. This tool will allow the team to provide a high-level summary of their work and can be updated as they continue to improve their program post IDN involvement.

A3 Lean Method

Project Title: Co-Pilot (C1/E5) **Date:12/11/2020**

Team: Maryanne Ferguson, Jen Seher, Gary Card, Terry Nash, Jim Duffy, Stephanie Worcester, and Eileen Fernandes

Project Background

The Co Pilot program will create a person/patient-centered environment that considers and respects the desires, values, family situations, social circumstances and lifestyle of the individual, (b) to develop and coordinate a team of clinical care and community services responsive to this environment that both meets the needs and preferences of the individual and empowers their capacity for self-efficacy and (c) learn and demonstrate that new structures, practices and work flows can create a transformational delivery culture that improves satisfaction and effectiveness.

This project entails two components creating a team approach to supporting Medicaid patients with Serious Mental Illness (SMI) and Severe and Persistent Mental Illness (SPMI) who are transitioning from a hospital setting back into the community: Critical Time Intervention and Enhanced Care Coordination.

Current Conditions

Observation / Data: The current system lacks the programmatic resources and skilled workforce necessary to address the increasing level of homelessness, hospital readmission, and use of the ED among individuals with serious mental health conditions. We lack a proven, evidence-based approach to effectively support this population.

SPECIFIC AIM STATEMENT: The AIM of this project is to prevent readmissions to acute care, inappropriate use of the ED, and recurring homelessness amount individuals with serious mental health conditions.

Goals/Objectives

Streamline access to services, reduce ER readmissions, improved quality of life for patients, improved individual and population-level health indicators, Social Determinants of health are routinely addressed along with medical care in an integrated way, improvements in management of chronic health conditions.

- Reduce the number of poor mental health days amongst adults from 3.8 in 2015 to 2.8 in 2019.
- Reduce overall homelessness in Cheshire county from 96 in 2016 to 86
- Reduce Social Isolation

Analysis

- Lack of consistent communication between service providers
- Lack of coordination of care between service providers
- Duplication of efforts regarding care coordination

- Lack of safe, affordable housing prevents clients from addressing social determinants of health
- Unmet needs like food security and social interaction result in adverse health events

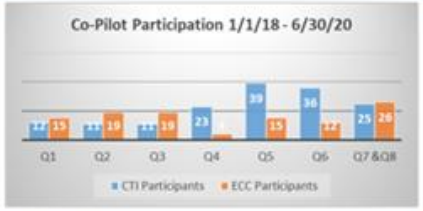
- A lack of an evidence based approach for treating people with severe and persistent mental illness results in unnecessary emergency room utilization.

Plan the Improvement

Do the Improvement

Check the Results

Results of a client survey concluded in December of 2018	
Decrease in client self-reported poor mental health days	Out of the 43% who answered the questions 85% reported a decrease
Increase in number of social interactions per week	62% Increase



Act & Determine Next Steps

Sustainability Plan:

- Enhanced Care Coordination services will be embedded in the Older Adult and Adult Case Management team to supplement additional services to those clients with co-occurring complex medical needs.
- Monadnock Collaborative will sustain Critical Time Intervention informed work through it's ongoing short term care coordination efforts in supporting patient transitions from hospital to community.

Project Targets

From the Evaluation Project Plan, use the format below to provide a list of the progress toward targets or goals that the program has achieved. Targets required by the STCs, include but should not be limited to:

- Number of individuals served (during reporting period and cumulative)
- All performance measures identified in the evaluation project plan.

The cumulative numbers below reflect initial totals based on the past few years of quarterly reporting. The IDN administrative team is working with the project team to better total actual participants served.

Year 2	Q1: 7/1-9/30/18	Q2: 10/1-12/31/18	Q3: 1/1-3/30/19	Q4: 4/1-6/30/19	Q5: 7/1-9/30/19	Q6: 10/1-12/31/19	Q7: 1/1-6/30/20	Q8: 7/1/-12/31/20	Cumulative/ Projected
Active Participants	27	*30*	*28*	*^26*	*39 CTI* *15 ECC* *54 Total*	*36 CTI* *12 ECC* *48 Total*	*51 Total*	CTI-18 ECC-36 **Total - 54**	318 / N/A
Pre CTI		1	1	2	11	5		18	166
Participants CTI Phase I	0	2	6	9	13	9			
Participants CTI Phase II	7	0	2	8	16	9			
Participants CTI Phase III	5	8	2	4	10	13	25 (all phases)		
Participants ECC	15	19	19	^3	15	12	26	36	115
# of Completed Participants to Date	11	15	21	23	11 CTI Closed 2 ECC (1 died; 1 consumer request)	4 additional CTI Graduates 1 CTI person died during phase 2.	n/a	CTI graduates-8 ECC- 5	
Total Number of Referrals from CMC-DHK		12 (7 CTI, 5 ECC)		16 CTI (2 declined)	24 CTI from CMC-DHK 8 ECC (3 DHK; 3 MFS; 2 ServiceLink)	12 CTI	CTI-8 ECC-16	CTI – 21 ECC - 17	126

Total Declined by Team		6 (Primarily due to Insurance elig.)		No CTI declined	1 CTI 0 ECC	2 CTI	CTI-1 ECC-0	CTI – 0 ECC – 1	11
Total Assigned but not engaging after 30 days					2 CTI	1 CTI	CTI-1 ECC-2	CTI – 8 ECC - 1	15

Budget

The Co-Pilot team experienced fluctuation for Salary/Wages and Employee Benefits over the seven periods as a result of staffing vacancies, new hires at a higher rate and changes in employee benefits elections. The staff member that remained consistent from the last quarter of CY 18 to date did not elect to take Health Insurance resulting in much lower costs. The new staff member did elect the coverage and therefore the costs rose significantly.

C1/E5: Copilot	CY 2016 Actuals	CY2017 Actuals	CY2018 Jan- June Actual	CY2018 July-Dec Actual	CY2019 Jan-Jun Actual	CY2019 Jul-Dec Actual	CY2020 Jan-June Actual	CY 2020 July - Dec Actual
Total Salary/Wages								
Employee Benefits								
Supplies (Technology etc.)								
Recurring Expenses								
Staff Education and Training								
One Time Expenses								
Total:		**$ 83,823.03**	**$ 118,661.00**	**$ 85,196.51**	**$ 95,484.80**	**$ 92,490.10**	**$ 108,446.49**	**$ 113,226.00**

Projects D: Capacity Building Focused

Narrative

Provide a detailed narrative which describes the progress made during this reporting period.

Overview of the PATP-IOP Project Architecture:

As reported in July, 2017 SAR

The PATP- IOP project pilot will build off of the existing structure of the Perinatal Addiction Treatment Program to develop and pilot an evidence-based, gender-specific, trauma-informed intensive outpatient treatment program to meet the critical treatment needs of pregnant and parenting women with substance use disorders (SUD) in the DSRIP Region 1 catchment area. The project will serve Medicaid-eligible women with substance use disorders who meet criteria for ASAM level 2.7 services, with a particular emphasis on the needs of women who are pregnant or parenting young children. The primary project objectives are as follows:

- Implement and evaluate an evidence-based, trauma-focused curriculum to meet the special needs of women qualifying for ASAM level 2.7 (Intensive Outpatient) services, including medication assisted treatment
- Address the comprehensive medical and psychiatric needs of participants through provision of co-located psychiatric and reproductive health services with linkages to primary and specialty medical care
- Develop protocols for comprehensive screening and service coordination to address social determinants of health which present particular barriers to treatment and recovery for women
- Provide on-site childcare to facilitate access to and engagement with treatment for women with young children
- Clearly define and develop the business case for a scalable, integrated intensive outpatient model of care for the target population
- Help women to consolidate their recovery as an investment in their own lives and their children's future

Currently the only gender-specific SUD treatment option in Region 1 is that provided by the Dartmouth-Hitchcock Perinatal Addiction Treatment Program (PATP) in Lebanon, a once weekly office-based outpatient program. The proposed project builds on the existing infrastructure of the current program, which includes deep knowledge of the social and health needs of this population, medication assisted treatment, weekly group therapy, peer support, integrated psychiatric and reproductive health care, and case management for pregnant and parenting women.

The PATP currently sees upwards of 40 woman during their two session clinical Wednesday. The IOP will target women from this pre-existing patient pool who need higher intensity services and from there will expand the number of individuals served. The proposed program will provide a replicable model for

increasing access to intensive substance use treatment services for a population with significant vulnerability and barriers to care. Specifically, we anticipate that:

- 25-50 women of reproductive age will be provided with comprehensive, intensive addiction treatment annually that they would not be able to access otherwise
- 25-50 women with difficult to treat co-occurring disorders will be provided access to psychiatric care and will have the opportunity to stabilize their mental health disorders

25-50 women and their children will be able to access resources needed to avoid homelessness, food insecurity, sexual exploitation and exposure to domestic violence.

Current State Updates from July - December 2020:

The Moms in Recovery (MIR) Program over the past six months has continued to be challenging for the patients and staff due to the worsening pandemic. They had believed in late summer to be able to resume offering in person groups, but as cases began to rise again locally, they decided that was not going to be safe. They continue to hope that by spring of 2021 they will be able to offer in person groups, whether indoors or outdoors. Barriers to in person groups continue to include patients who are not adherent to proper mask-wearing and inability to offer childcare.

The MIR program continues to offer the Daily Intensive Program (1.5 hour group 5 days per week) via telehealth in place of the traditional IOP (3 hours per day 3 days per week). This has been helpful for a number of women in stabilizing their lives after a relapse and helping them transition out of residential treatment. The program also continues to offer outpatient groups via telehealth. Staff does not currently require group attendance for all patients, which is a change from the pre-pandemic practice. Some women are unable to attend telehealth groups due to lack of technology/internet access, work schedule, or simply patient preference. This has been challenging as groups are an efficient way to care for a larger number of people. When women are not engaging in groups, they tend to require more individual visits with clinicians and/or Medical Doctors (MDs). The program continues to offer in person individual visits where appropriate as well as clinic visits for urine drug screens (UDS).

With rising cases locally, the program continues to see some Covid-related challenges in the clinic. They are discouraging "drop in" visits to the clinic and are asking women to attend on time and only at scheduled times to reduce the number of people in the office at a given time. They have seen some aberrant behaviors related to Covid, which have occurred in both directions. Examples include patients not disclosing Covid symptoms, exposure, or test results prior to coming to the office for an appointment, thereby potentially exposing staff. In addition, we have seen women use potential Covid exposure or symptoms (even when we can see negative test results in the medical record) as a reason not to come provide a UDS when they are using substances and do not want this use to be detected. The program is also continuing to see issues with proper mask-wearing, as above (patients do not always keep their masks over their nose and mouth throughout the visit). Fortunately, staff are not aware of any transmission of illness from patient to patient or from patient to staff, which likely reflects the success of de-densifying the clinic and consistent staff adherence to mask wearing and eye protection.

The program will be piloting having a family medicine physician on site one day per week in January of 2021 to try to address the primary care needs of our patients. We continue to have a Midwife on site one day per week for women's health services, but they have found it challenging to provide the level of

integrated care they were able to offer in the past. Care in the telehealth environment tends to feel a bit more fragmented and less coordinated than care in the clinic.

The program was fortunate to be able to help a number of patients with the Governor's Office for Emergency Relief and Recovery (GOFERR) funding at the end of last year and also to share donated holiday gifts with the families. These supports were greatly appreciated this year as many of the families are facing even more financial stress than usual. Housing, intimate partner violence, and alcohol and cannabis use all remain concerns that have been intensified by the pandemic. Women also report high degrees of stress related to remote schooling and the uncertainty of changing school schedules.

The project team completed the project year with an A3 (below) showcasing their ongoing work over the past few years. While the program will continue to be sustained, they will not be continuing as a formal IDN project partner. Continued sustainability will be supported by the larger Dartmouth Hitchcock system, and they will continue to look for external funding sources to support their ongoing work and improvement until an alternative payment model has been implement to pay for the much needed services.

A3 Lean Method

Project Title: Moms in Recovery – Intensive Outpatient (MIR-IOP)

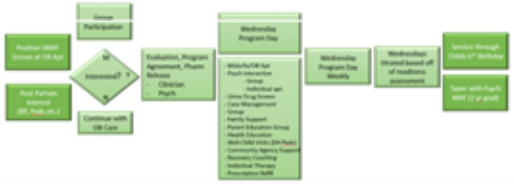
Date:12/8/2020

Team: Julia Frew, MD, Daisy Goodman, DNP, MSN, MPH, CNM, APRN, Teri LaRock, MSW, LICSW, Cheri Bryer, Tonya Suarez, MSW, LICSW, Linda Snow, Leah Abrahamsen MSW, LICSW, Martha Catalona, BSN, Melissa Baughman, MA, Stephanie Grey,

Project Background

Develop and pilot an evidence-based, gender specific, trauma-informed intensive outpatient treatment program to meet the critical treatment needs of pregnant and parenting women with substance use disorders (SUD) in the DSRIP Region 1 catchment area.

Current Conditions



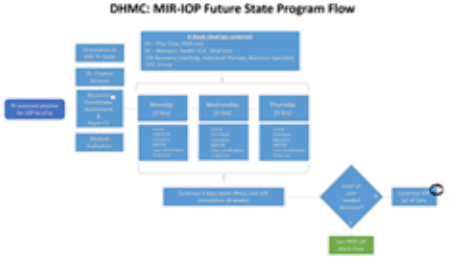
Goals/Objectives

- Implement and evaluate a curriculum grounded in evidence-based treatment strategies to meet the special needs of women qualifying for ASAM level 2.7 (Intensive Outpatient) services, including medication assisted treatment
- Address the comprehensive medical and psychiatric needs of participants through provision of co-located psychiatric and reproductive health services with linkages to primary and specialty medical care
- Develop protocols for comprehensive screening and service coordination to address social determinants of health which present particular barriers to treatment and recovery for women
- Provide on-site family support to facilitate access to and engagement with treatment for women with young children
- Clearly define and develop the business case for a scalable, integrated intensive outpatient model of care for the target population
- Help women to consolidate their recovery as an investment in their own lives and their children's future
- 25-50 women of reproductive age will be provided with comprehensive, intensive addiction treatment annually that they would not be able to access otherwise
- 25-50 women with difficult to treat co-occurring disorders will be provided access to psychiatric care and will have the opportunity to stabilize their mental health disorders
- 25-50 women and their children will be able to access resources needed to avoid homelessness, food insecurity, sexual exploitation and exposure to domestic violence.

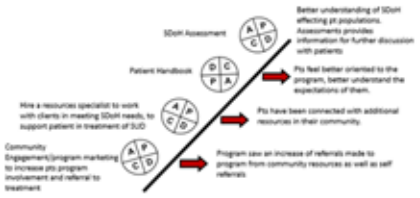
Analysis

- In 2016, 563 births at D-H occurred to residents of Region 1. Approximately 10% of all births at D-H are affected by opioid use disorders, and nearly all of these mothers are insured by NH Medicaid.
- Mothers of preschool-aged children would also be eligible for services.
- Women of reproductive age would be provided with comprehensive, intensive addiction treatment annually that they would not be able to access otherwise.
- Women with difficult to treat co-occurring disorders will be provided access to psychiatric care and will have the opportunity to stabilize their mental health disorders.
- Women and their children will be able to access resources needed to avoid homelessness, food insecurity, sexual exploitation and exposure to domestic violence

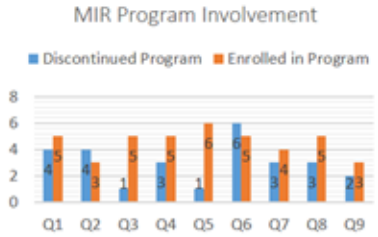
Plan the Improvement

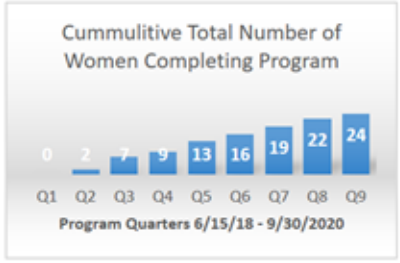


Do the Improvement



Check the Results





Act & Determine Next Steps

- Continue researching opportunities to offer blood draws for labs tests such as Hepatitis B, Hepatitis C, HIV Screening
- Research opportunities for sustainable Yoga offerings in clinic
- Continue to conduct PDSAs on patient pathways in and out of program

Project Targets

Use the format below to provide a list of all of the progress toward targets that the program has achieved. Targets should include

- Number of individuals served (during reporting period and cumulative)
- All performance measures identified in the evaluation project plan.

The PATP-IOP project team during July - December, 2020 continued collecting on the seven defined core performance measures which were selected as the foundation for program evaluation. Those measures and their operational definitions can be found below. Any formal changes or additions will be captured in subsequent reporting.

Performance Measure Name	Target	Progress Toward Target						
		As of 12/31/17	As of 6/30/18	As of 12/31/18	As of 6/30/19	As of 12/31/19	As of 6/30/20	As of 12/31/20
Number of Medicaid women successfully completing the IOP program		Program Not Started	N/A	7	13	19	22	30
Number of women engaged in continuing care one month following completion of IOP			N/A	7 (All require other level of care)	8	15	2	27
Number of negative UDS at end of program			N/A	2	10	19	22	25
Number of women receiving reproductive health services visit			89%	100%	13	98%	97%	90%
Number of pregnant women who attend recommended prenatal visits during program			100%	100%	100%	100%	100%	100%
Number of women with established PC relationship			78%	58%	43%	53%	67%	unknown
All program participants are screened for SDoH			78%	89%	82%	81%	50%	61%
STC Defined Program Measures								
All performance measures identified within the evaluation plan milestones	100%	100%	100%	100%	100%	100%	100%	100%
Operationalization of Program								
A. Implementation of Workforce Plan								
B. Deployment of Training Plan								
C. Implementation of any required updates to clinical protocols, or other operating policies and procedures	100%	100%	100%	100%				

D. Use of assessment, treatment, management and referral protocols					100%	100%	100%	100%
Initiation of Data Reporting								
A. Number of individuals served vs. projected			75%	75%	75%	75%	75%	75%
B. Number of staff recruited and trained (during reporting period and cumulative) vs. projected			100%	100%	100%	100%	100%	100%
C. Impact measures as defined in evaluation plan, including annual evaluation of fidelity to evidence-supported program elements	100%	100%	100%	100%	100%	100%	100%	100%

PATP-IOP Expansion Program Performance Measures	**Cumulative to 9/30/19**	**Cumulative to 12/31/19**	**Cumulative to 6/30/20**	**Cumulative to 12/31/20**
1) Number of women successfully completing the IOP program	16	19	22	30
Number of women enrolled	5	4	5	4
Number of women discontinuing program prior to completion*	19	22	25	28
Residential treatment recommended, treatment status unknown	8	10	2	25
Residential treatment confirmed	3	4	2	9
No known treatment on discontinuation of program	6	2	2	8
2) Number of women engaged in continuing care one month following completion of IOP	15		2	27
o Continuing Care is:				
§ Return to OP level of care at Moms in Recovery	11	3	2	27

§ Transfer to other OP or IOP	2	0	3	3
§ Discharge to higher level of care	2	1	2	9
3) Number of women with negative UDS at end of residential program*	17	19	22	25
o Less than 50% testing positive for THC by the end of an IOP	24%	26%	30%	29%
o Less than 25% testing positive for any non-prescribed substance other than THC	46%	47%	34%	49%
4) Number of women receiving reproductive health services visit	97%	98%	97%	90%
Hepatitis B screening*	43%	49%	33%	56%
Hepatitis C screening*	43%	49%	33%	56%
HIV screening*	43%	49%	67%	56%
Chlamydia and gonorrhea screening	70%	74%	67%	61%
§ PAP history reviewed, updated if indicated	84%	81%	67%	76%
Had family planning discussion (OKQ)	97%	98%	100%	78%
5) Number of pregnant women who attend recommended prenatal visits during program*	100%	100%	100%	100%
6) Number of women with established relationship with a primary care	54%	53%	67%	Unknown
o At least one visit with a PCP in the past 12 months	38%	40%	67%	unknown
7) All program participants are screened for Social Determinants of Health*	78%	81%	50%	61%

o % of patients identifying concern for the following:				
§ Housing	48%	51%	67%	56%
§ Financial Strain	83%	86%	67%	92%
§ Education	7%	6%	0%	3%
§ Social Isolation	10%	9%	0%	3%
§ Transportation	72%	77%	100%	83%
§ Employment	55%	57%	67%	61%
§ Legal Issues	38%	31%	0%	33%
§ Interpersonal Safety	41%	43%	**0%**	**44%**

Budget

Provide a narrative and a brief project budget outlining actual expenditures and projected costs to support the community project which must include financial reporting

D3: PATP/IOP (Moms in Recovery)	CY 2016 Actuals	CY 2017 Actuals	CY 2018 Jan-June Actual	CY 2018 July-Dec Actual	CY 2019 Jan-June Actual	CY 2019 July - Dec Actuals	CY2020 Jan-June Actuals	CY 2020 July - Dec Actuals
Total Salary/Wages								
Employee Benefits								
Supplies								
Purchased Service								
Staff Education and Training								
Other: Cost								
Total			$ 118,014.60	$ 118,014.60	$ 94,730.15	$ 124,969.46	$ 138,065.33	$ 134,032.40
Projected Revenue Offset			*$ 62,568.20*	*$ 62,568.20*	*$ 62,568.20*	*$ 62,568.20*	*$ 62,568.20*	*$ 62,568.20*
Total IDN Funds			**$ 55,446.40**	**$ 55,446.40**	**$ 55,446.40**	**$ 62,401.26**	**$ 75,497.13**	**$ 71,464.20**

Projects E: Integration Focused

Narrative

Provide a detailed narrative which describes the progress made during this reporting period.

E5 Project Background

Region 1 IDN E5 work is spread across three types of projects which are outlined in the different reporting sections below. The Sullivan County Complex Care Team (SCCCT) is the main E5 project which has been in process since 2018. This project brings together multiple community based stakeholders who present de identified complex care cases for the team to discuss and provide insight in next steps for the presented case. The second E5 project is an extension of the SCCCT known as the Sullivan County Community HUB. This project looks to improve closed loop referrals for complex cases across the different community members that a patient/client may need to accommodate whole patient/client care. This is done through the completion of pathways which is a process of steps taken to resolve a need for social determinants of health and/or a behavioral health need. During the past reporting period, this team evolved the mission to address the needs in the community due to the impact of COVID-19. Finally, the third E5 project is in association with the Co-Pilot project described and reported on more in detail in the C1 SAR section. The Co-Pilot project is a melding of the C1 and E5 projects. The details for this third project are primarily covered in the C1 section where as the other two have more details in the following reporting sections.

Updates as of July – December, 2020:

Sullivan County Complex Care Team Meetings: No change to meeting structure in the current term

The Sullivan County Complex Care Team (SCCCT) continues to meet the needs of providers and stakeholders in Sullivan County in addressing complex needs. During the reporting period, COVID-19 presented an opportunity to expand the offerings of the SCCCT. In March 2020, we migrated the SCCCT platform to virtual monthly WebEx meetings. Community providers then began to request "Ad-hoc" calls for some high acuity patients that they were serving. The SCCCT facilitator coordinated a small, concentrated team to address the complex needs outside of the larger SCCCT. These "ad-hoc" meetings have been stood up quickly for providers to explore the next best steps for patients in uncertain times. Providers can request meetings at any point and typically have a meeting within 48 hours of their request.

The larger SCCCT group continues to meet monthly to provide updates on previous cases, share on-going changes to important resources and collaboratively work through complex community cases. The migration from in-person to virtual meetings has proven effective in engaging new providers in the conversation and expanding the opportunity for current providers to come to the table. To continue the sustainability process of the SCCCT, a proposal has been made to the team to rotate community-based facilitation to drive home the importance of community ownership with this project and to ensure sustainability. Proposed plan is drafted below:

Proposed Sustainability Plan for Sullivan County Complex Care Team

Beginning in February 2021, the below plan outlines a proposed method for sustaining the work of the Sullivan County Complex Care Team Meeting post administrative team support from the IDN.

- The IDN will send out the calendar notifications through July 2021.
- Each month the SCCCT Facilitator will rotate between an organization or service provider in Greater Sullivan County. The hope is that this will generate shared ownership of the meeting series. Whoever is designated to facilitate for the month would be responsible for sending out a notice to provider partners requesting and securing a case presenter for the month.
- Proposed schedule:

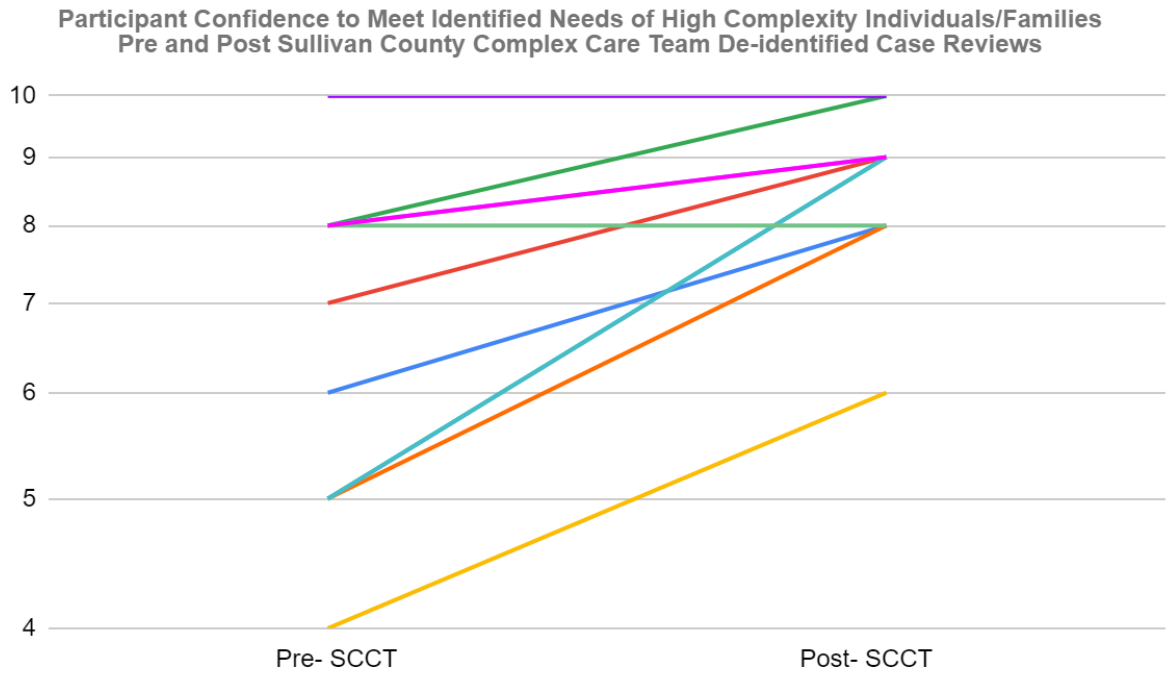
Month	Facilitator
February	[redacted]
March	
April	
May	
June	
July	
August	

Proposed Meeting Structure

- The facilitator each month will begin the meeting outlining meeting standards and privacy practices.
- The presenter is responsible for outlining goals of the case, following a general case presentation.
- The presenter is responsible for their own outcomes, notetaking, and doing any follow up that is pertinent to the case presentation.
- The facilitator is only responsible for maintaining meeting standards, guiding the conversation, or illicit questions to help the reach the goals of the presenter.

In addition, the SCCCT facilitator began tracking the confidence levels of the presenter pre/post SCCCT at both the "Ad-hoc" and larger SCCCT meetings. Data below indicates that the majority of providers feel more confident, when they present a case to their peers and have more information to make appropriate referrals for complex cases.

It is the hope of the IDN1 administrative team that come July, 2021 the group will be self-sustaining through ongoing coordination and facilitation by community partners.



Expansion of work utilizing the Pathways Community Hub Model in Sullivan County Hub Pilot:

During the reporting period, the COVID-19 pandemic impacted both the implementation and launch of the Community Hub pilot project in Sullivan County. Significant headway had been made on building a foundation for assessment, policy, and procedure for the identified pathways for the pilot.

Since March 2020, the Hub Manager approached the Steering Committee with several options on how best to progress with the Hub pilot. The Steering Committee unanimously agreed to support the local community non-profits in a coordinated effort. On March 31, 2020, the Greater Sullivan County COVID-19 Community Response Coalition launched. In early May, the group renamed as Greater Sullivan Strong (GSS). Many of the original identified pathways (housing, transportation, food access, and behavioral health) for the Hub pilot have been areas that GSS has been able to tackle during the COVID-19 crisis.

The work of Greater Sullivan Strong continues with the spirit of the Hub pilot, by bringing community partners together, breaking down siloes, and creating opportunities for collaboration across sectors. This large group of 65 individuals and 30+ organizations met bi-weekly until late August and continues to meet monthly to address the community needs surrounding COVID-19. Most recently GSS has voted to return to a bi-weekly meeting to address the needs of the COVID-19 surge in a timely manner. GSS has been able to provide emergency relief funding to over 44 agencies with donations from Dartmouth-Hitchcock Population Health, Dartmouth-Hitchcock Philanthropy, the Endowment for Health, New Hampshire Charitable Foundation, and the many local donors of Greater Sullivan County. Notably, Greater Sullivan Strong has been able to close gaps in food access throughout the region, increase tele-commuting capacities for mental health and SUD providers, and serve nearly 100 families with direct-relief dollars. In addition, GSS has made it possible for local non-profits to access rapid emergency relief dollars to continue to provide the community with essential safety net services.

The IDN strives to act as a connection for new organization collaboration in program implementation and to leverage the inter-organization relationships that are successfully delivering care across the region today. The success of Greater Sullivan Strong is due to this connectivity and inter-organization relationships established by the IDN. Additionally, the IDN in partnership with the PHAC, developed a community coalition that will sustain itself throughout the recovery and reopening during the COVID-19 pandemic.

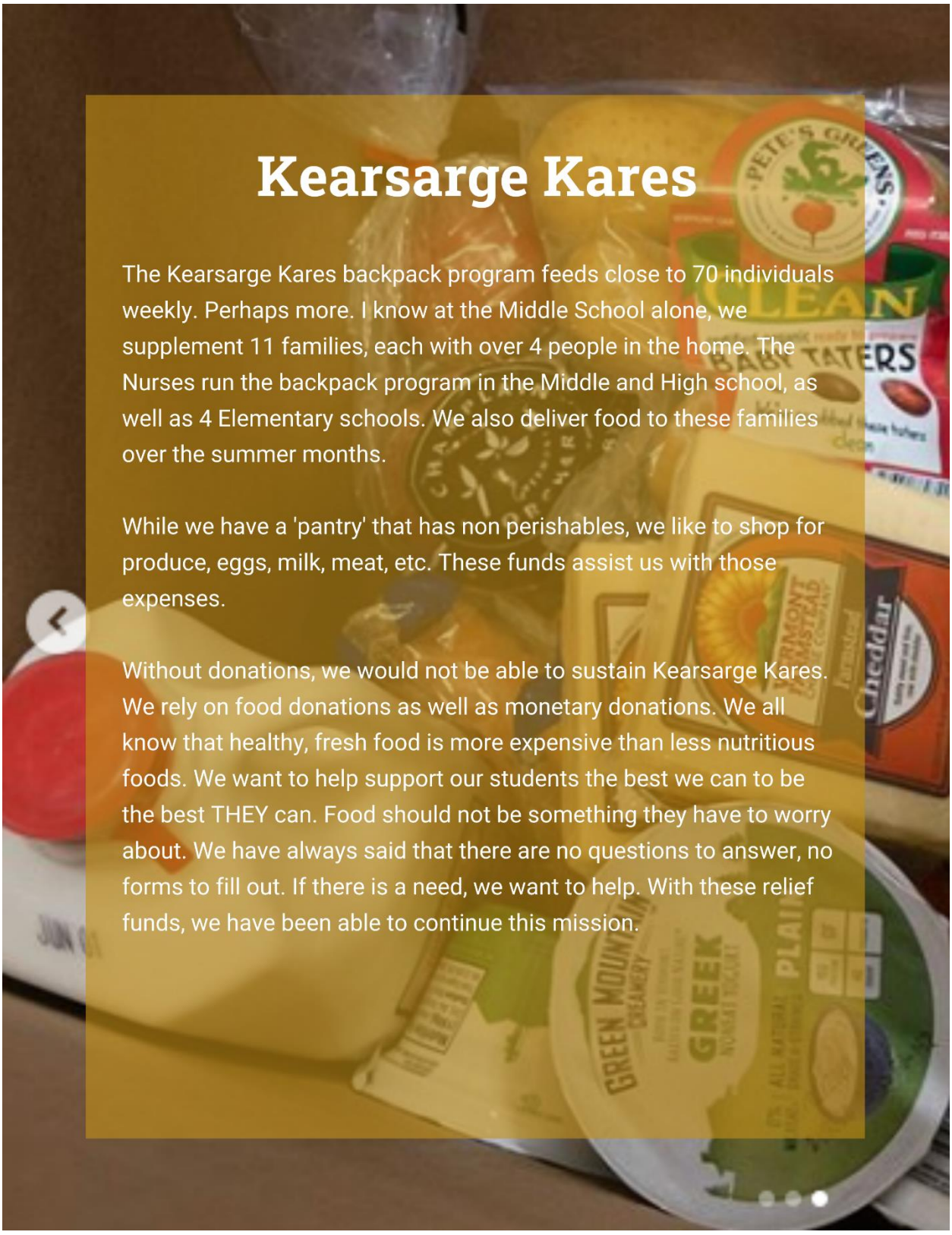
For CY2021 sustainability of the GSS work there will be a shift in management of the GSS in January, 2021 as the Community HUB manager will be leaving her position on January 8th. The IDN will continue to be involved with the work of GSS but meeting facilitation and administrative tasks will be transferring to an individual supported by the DH-H health system and the Greater Sullivan County PHAC. Additionally, there has been a transition of the fiscal organization supporting the work of GSS and the shift in day to day management works in line with that transition. It is the collective regions intention to sustain GSS post the need for COVID-19 response in the community and the hope that in sustaining the group's functional structure the community will be well poised to handle any significant need that may come its way.

The below infographics and PDFs are a sampling of the work that continues with GSS. Attached is the GSS 2nd and 3rd round funding impact report from the Community Relief Fund. These documents illustrate the many partnerships and work of collaboration to best meet the needs of the entirety of Greater Sullivan County.

By The Numbers

	**32** **Number of non-profit requests granted**	Nearly $100,000 have been granted to non-profits in Greater Sullivan County to support families and individuals experiencing difficulties during the pandemic through the Relief Fund
	**50%** **Increase**	A local Community Dental Center was able to increase both capacity and revenue by 50% due to dollars granted through the Community Relief Fund
	**82** **Clients**	Served with Funds from the Community Relief Fund by providing new, updated technology to run hybrid (online + in-person) recovery support groups more effectively
	**50%** **of Greater Sullivan County**	Has been served with the Community Relief Fund. We are still looking to serve the remaining 50% of the region


Charlestown Community Garden
The Charlestown Community Garden currently has 28 garden beds, serving 20 families and the Charlestown Food Shelf. In addition to these families, the awareness of the ability to grow one's own food has grown through conversation and excitement surrounding this project.
The relief dollars from the Greater Sullivan County COVID-19 Community Relief Fund made it possible to have water at our site. Without the Greater Sullivan County COVID-19 Community Relief Fund, we would not be able to purchase and maintain a water tank on site and water would have to have been carried in by each participant. This would have made the garden inaccessible to many who do not have the capability of carrying heavy water jugs to their garden beds.
The Greater Sullivan County COVID-19 Community Relief Fund has made a tremendous difference in the lives of many families, directly at the Charlestown Community Garden for the opportunity to grown their own food in a beautiful and accessible location and indirectly through the ability of volunteers to bring forth a project that benefits Charlestown citizens at a time when everyone needs something tangible to feel good about. We could not have provided this without your support.

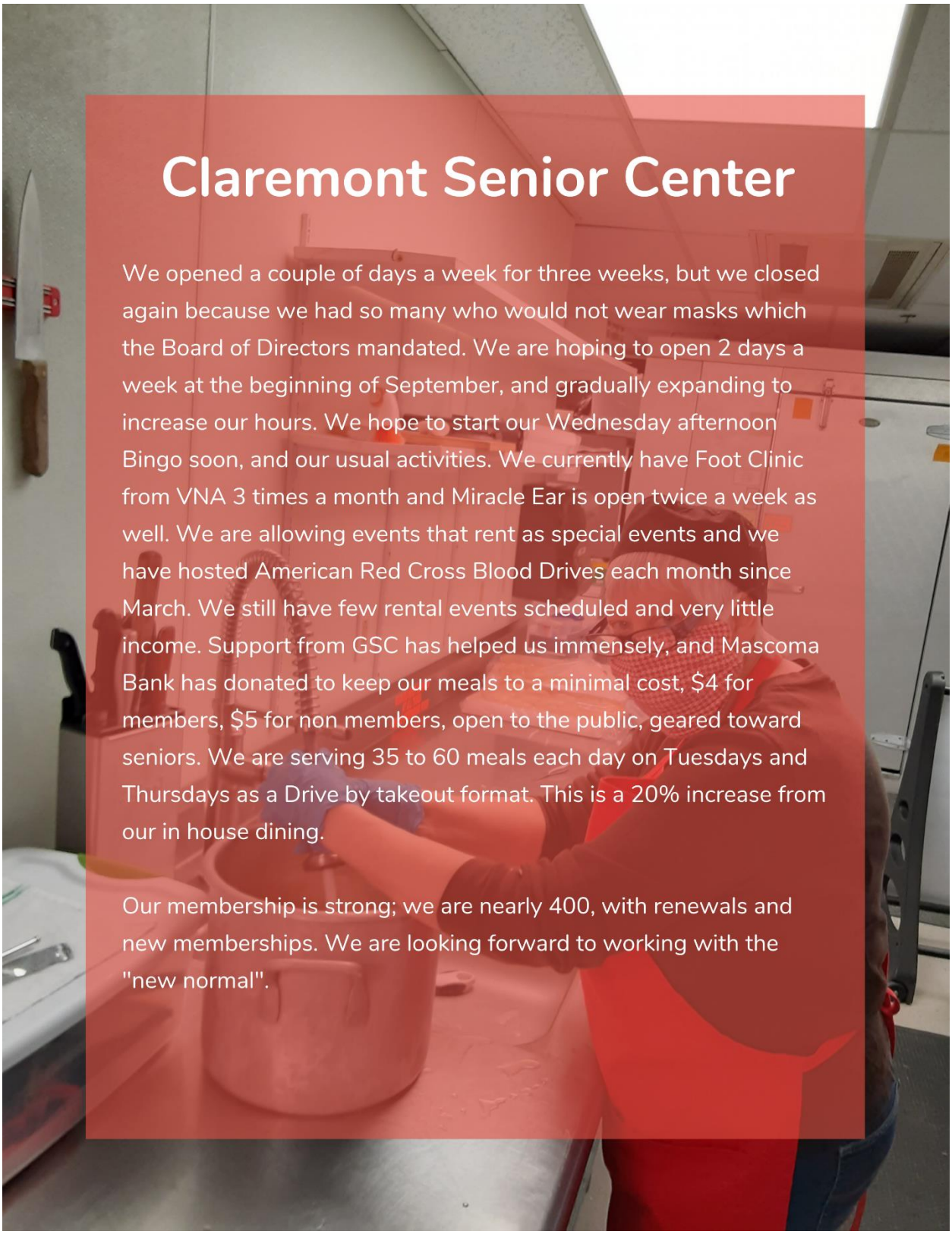


Kearsarge Kares

The Kearsarge Kares backpack program feeds close to 70 individuals weekly. Perhaps more. I know at the Middle School alone, we supplement 11 families, each with over 4 people in the home. The Nurses run the backpack program in the Middle and High school, as well as 4 Elementary schools. We also deliver food to these families over the summer months.

While we have a 'pantry' that has non perishables, we like to shop for produce, eggs, milk, meat, etc. These funds assist us with those expenses.

Without donations, we would not be able to sustain Kearsarge Kares. We rely on food donations as well as monetary donations. We all know that healthy, fresh food is more expensive than less nutritious foods. We want to help support our students the best we can to be the best THEY can. Food should not be something they have to worry about. We have always said that there are no questions to answer, no forms to fill out. If there is a need, we want to help. With these relief funds, we have been able to continue this mission.



Claremont Senior Center

We opened a couple of days a week for three weeks, but we closed again because we had so many who would not wear masks which the Board of Directors mandated. We are hoping to open 2 days a week at the beginning of September, and gradually expanding to increase our hours. We hope to start our Wednesday afternoon Bingo soon, and our usual activities. We currently have Foot Clinic from VNA 3 times a month and Miracle Ear is open twice a week as well. We are allowing events that rent as special events and we have hosted American Red Cross Blood Drives each month since March. We still have few rental events scheduled and very little income. Support from GSC has helped us immensely, and Mascoma Bank has donated to keep our meals to a minimal cost, $4 for members, $5 for non members, open to the public, geared toward seniors. We are serving 35 to 60 meals each day on Tuesdays and Thursdays as a Drive by takeout format. This is a 20% increase from our in house dining.

Our membership is strong; we are nearly 400, with renewals and new memberships. We are looking forward to working with the "new normal".

By The Numbers

	**44** **Number of non-profit requests granted**	Over $120,000 have been granted to non-profits in Greater Sullivan County to support families and individuals experiencing difficulties during the pandemic through the Relief Fund
	**1,600** **Snacks**	The local community college was able to purchase $600 worth of snacks for students to grab and go during the school day. This was in addition to their food shelf on campus
	**350** **Participants**	A court diversion program serving Greater Sullivan County was able to take a small grant and upgrade their internet and wifi to better support 350 program participants in better connectivity
	**20** **Clients**	The Community Relief Fund helped to establish a mobile model for professional clothing delivery to help those enter back into the workforce after losing employment. More than 20 clients have been served

Organizations That Have Been Provided Funding Support

Family Supports

TLC Family Resource Center
Baby Steps Family Assistance
Valley Court Diversion Program
Sullivan County Humane Society
Southwestern Community Services
Shining Success
Millie's Place

Food Access

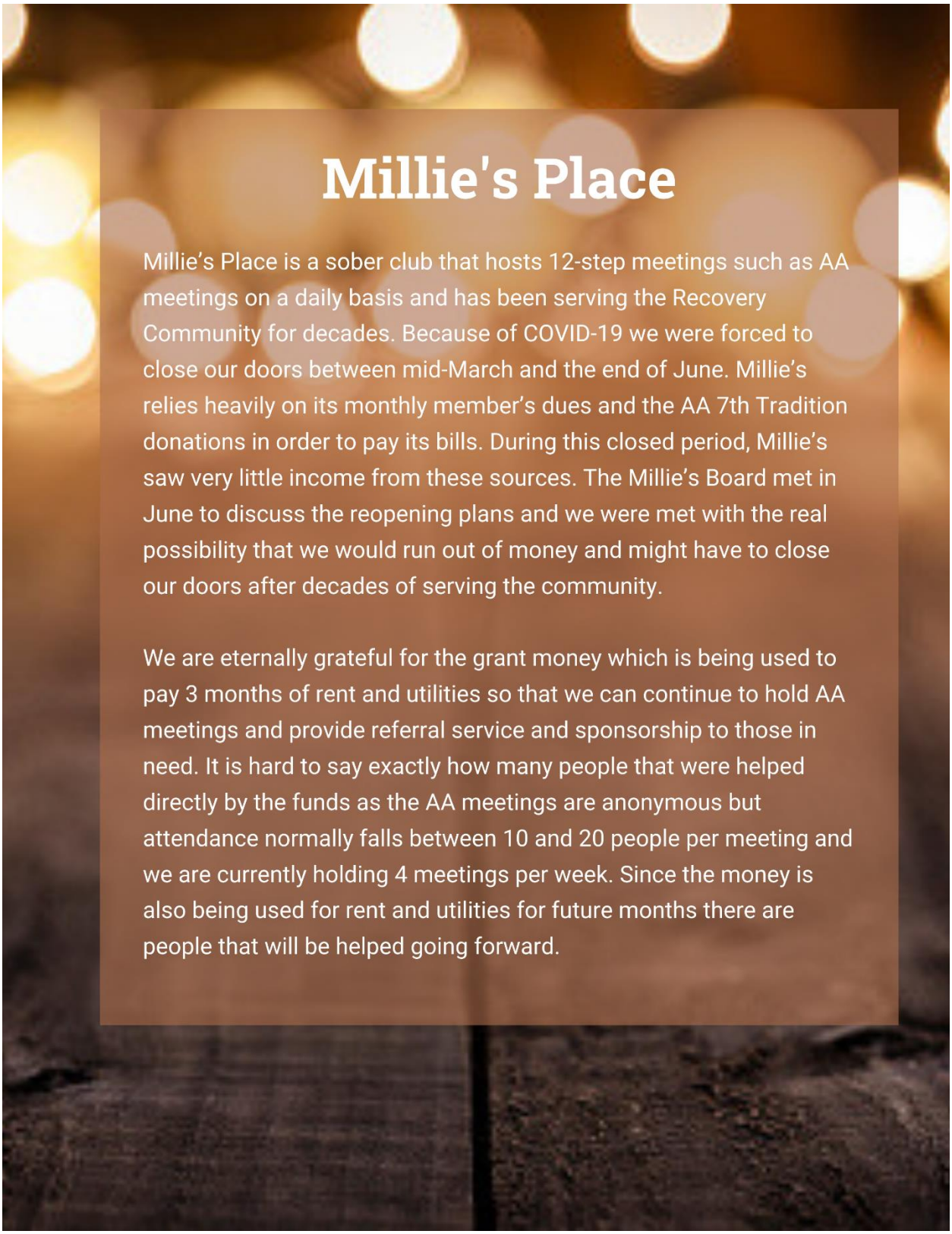
Got Lunch! Newport
Claremont Soup Kitchen
Kearsarge Kares
Kearsarge Food Hub
Charlestown Community Garden
Kearsarge Lake Sunapee Community Food Pantry
Colby-Sawyer College
Sullivan County Nutrition

Maintaining Older Adult Health

Maple Manor Apartments
Claremont Senior Center
Kearsarge Council on Aging- Chapin Center
ServiceLink
Lake Sunapee VNA and Hospice

Health and Other Organizations

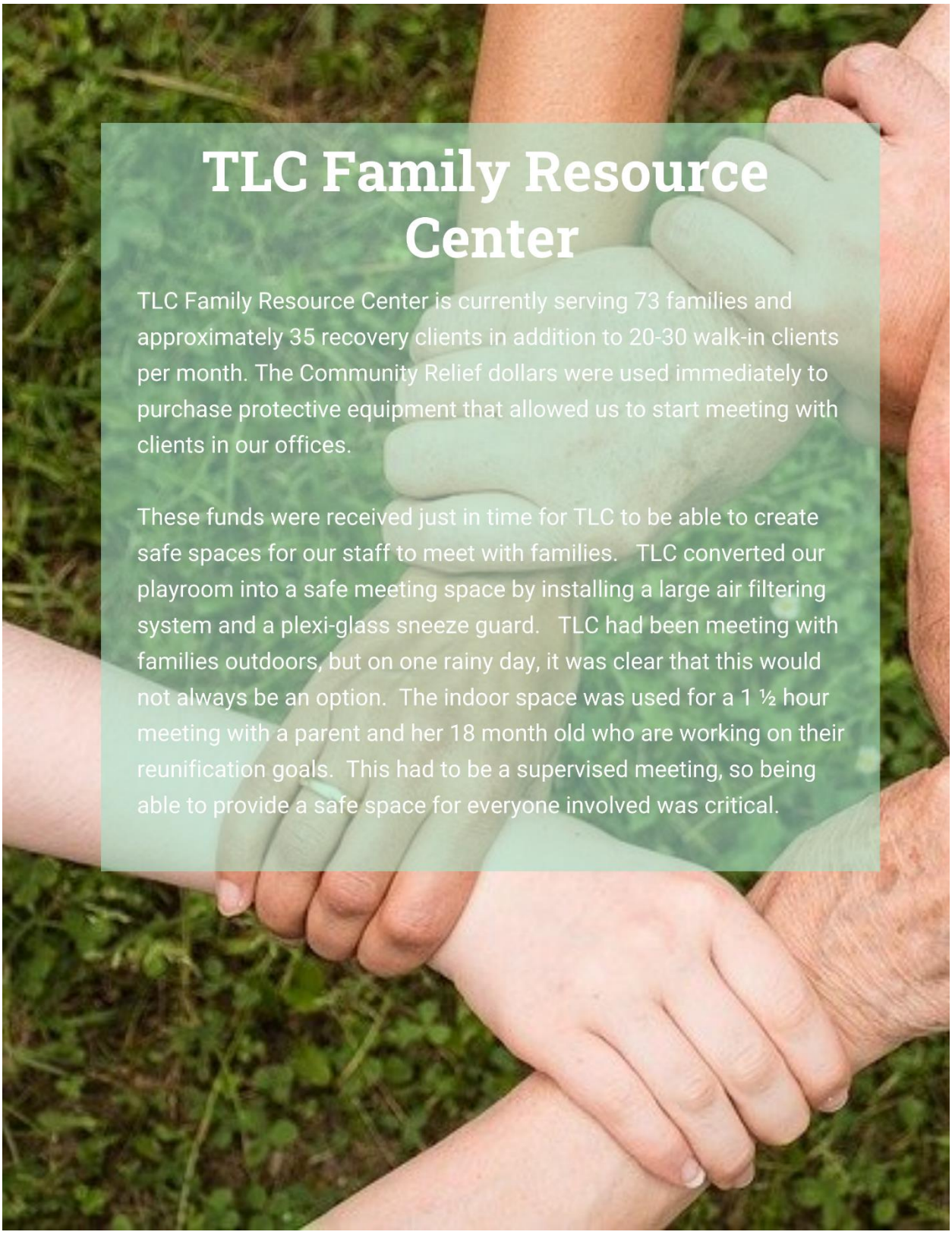
Sullivan County Oral Health Collaborative
Headrest, Inc.
West Central Behavioral Health
The Center for Recovery Resources
The Greater Claremont Chamber of Commerce



Millie's Place

Millie's Place is a sober club that hosts 12-step meetings such as AA meetings on a daily basis and has been serving the Recovery Community for decades. Because of COVID-19 we were forced to close our doors between mid-March and the end of June. Millie's relies heavily on its monthly member's dues and the AA 7th Tradition donations in order to pay its bills. During this closed period, Millie's saw very little income from these sources. The Millie's Board met in June to discuss the reopening plans and we were met with the real possibility that we would run out of money and might have to close our doors after decades of serving the community.

We are eternally grateful for the grant money which is being used to pay 3 months of rent and utilities so that we can continue to hold AA meetings and provide referral service and sponsorship to those in need. It is hard to say exactly how many people that were helped directly by the funds as the AA meetings are anonymous but attendance normally falls between 10 and 20 people per meeting and we are currently holding 4 meetings per week. Since the money is also being used for rent and utilities for future months there are people that will be helped going forward.

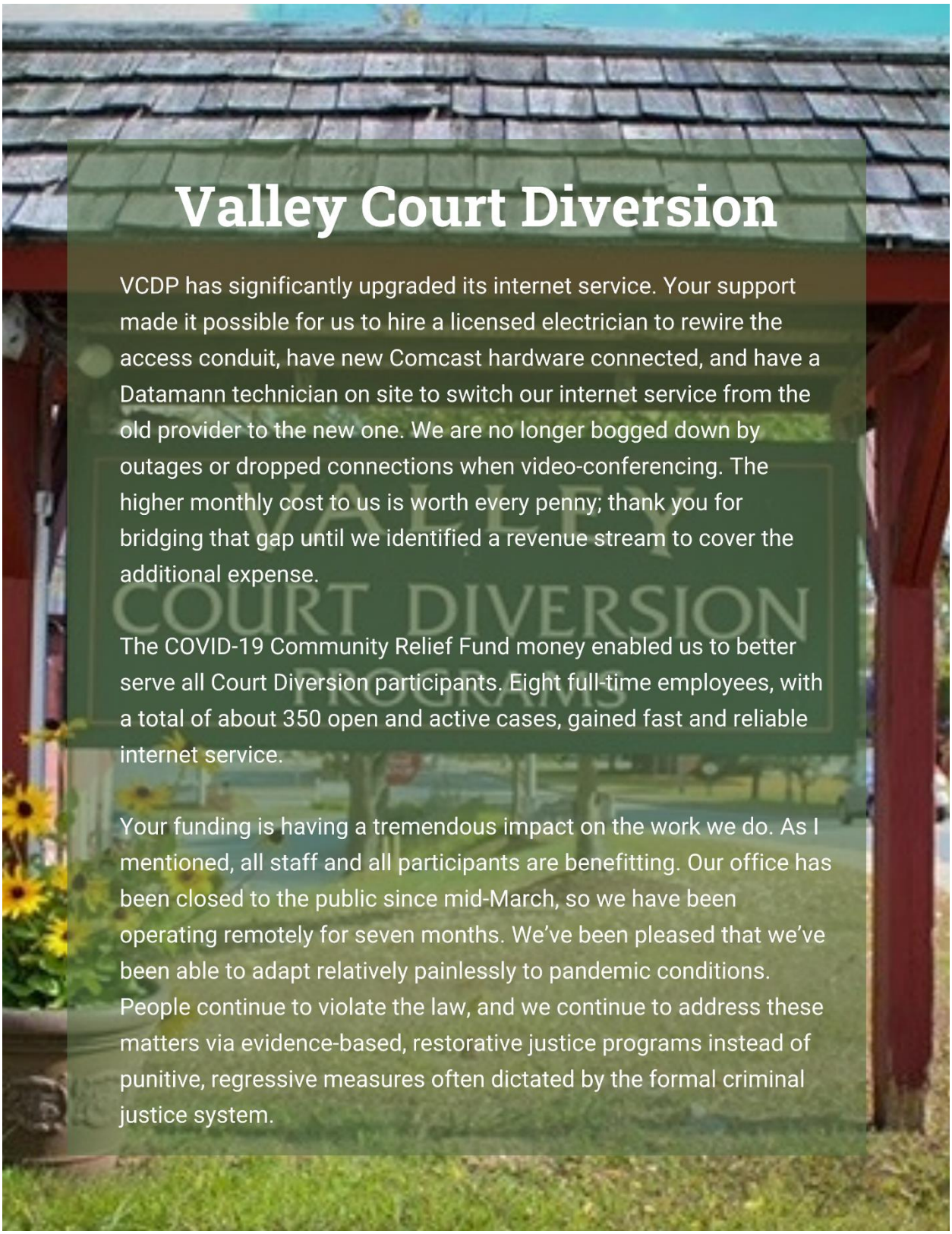

TLC Family Resource Center
TLC Family Resource Center is currently serving 73 families and approximately 35 recovery clients in addition to 20-30 walk-in clients per month. The Community Relief dollars were used immediately to purchase protective equipment that allowed us to start meeting with clients in our offices.
These funds were received just in time for TLC to be able to create safe spaces for our staff to meet with families. TLC converted our playroom into a safe meeting space by installing a large air filtering system and a plexi-glass sneeze guard. TLC had been meeting with families outdoors, but on one rainy day, it was clear that this would not always be an option. The indoor space was used for a 1 ½ hour meeting with a parent and her 18 month old who are working on their reunification goals. This had to be a supervised meeting, so being able to provide a safe space for everyone involved was critical.

Kearsarge Food Hub

Kearsarge Food Hub is able to serve nearly 500 people through partnerships with food pantries in the area, plus an additional 75+ people through partnerships with the Kearsarge Regional School District school backpack programs. With the new cold storage space, we are confident that we can sustain and even grow these numbers with greater capacity for storing foods all year long.

The relief dollars took a little longer to remedy challenges inherent in food distribution related to cold storage due to financing and manufacturing delays. The original plan when we applied for funds was to use what we received to build a makeshift cooler using an insulated room and coolbot technology. However, because a generous major donor was able to contribute funds to this project, we were able to get a brand new 10x14 walk-in cooler installed at our headquarters. This piece of equipment is high quality, reliable, commercial grade, and complies with all food safety requirements, now enabling us to take our food security efforts to the next level.

In our grant application we aimed to see a 25% increase in food security efforts with this storage capacity. That being said, our food security programs have grown by nearly 300% so far this year and we are committed to expanding them further, and this new cold storage will be key in allowing us to do so.


Valley Court Diversion
VCDP has significantly upgraded its internet service. Your support made it possible for us to hire a licensed electrician to rewire the access conduit, have new Comcast hardware connected, and have a Datamann technician on site to switch our internet service from the old provider to the new one. We are no longer bogged down by outages or dropped connections when video-conferencing. The higher monthly cost to us is worth every penny; thank you for bridging that gap until we identified a revenue stream to cover the additional expense.
The COVID-19 Community Relief Fund money enabled us to better serve all Court Diversion participants. Eight full-time employees, with a total of about 350 open and active cases, gained fast and reliable internet service.
Your funding is having a tremendous impact on the work we do. As I mentioned, all staff and all participants are benefitting. Our office has been closed to the public since mid-March, so we have been operating remotely for seven months. We've been pleased that we've been able to adapt relatively painlessly to pandemic conditions. People continue to violate the law, and we continue to address these matters via evidence-based, restorative justice programs instead of punitive, regressive measures often dictated by the formal criminal justice system.

E5 Work as Part of Co-Pilot Project (see C1 SAR section for more detail) Update:

E5 team as part of the Co-Pilot project is conducted by Monadnock Family Services. In the summer of 2019, the project was challenged with smooth transitions between the enhanced care coordination team (ECC) and the Critical Time Intervention (CTI) (Service Link) team. It was decided that each of the project participating organizations would be responsible for a level of care coordination, and they would continue to communicate regularly on a monthly bases.

Project Targets

Use the format below to provide a list of all of the progress toward targets that the program has achieved. Targets should include

- Number of individuals served (during reporting period and cumulative)
- All performance measures identified in the evaluation project plan.

Performance Measure Name	Target	Progress Toward Target						
		As of 12/31/17	As of 6/30/18	As of 12/31/18	As of 6/30/19	1/1/19 - 12/31/19	1/1/20-6/30-20	7/1/20-12/31/20
Number of Cases Reviewed by the SCCCT	24 Cases (Annual)	N/A	N/A	6	11 since January,2019 additional reoccurring *Two meeting times used for privacy and consent or would be on track to hit target.	26 Cases	12	4
SCCCT Referrals Made and Closed	100%	N/A	N/A	Not tracking	Process for tracking being created	100%	100%	100%
Expansion of SCCCT Membership	40 Organization	N/A	N/A	Addition of the following; Newport Health Center, NLH Representation, VRH representation, Valley Primary Care	Addition of the following: APD, DHMC Outpatient CHW representatives from all area medical agencies	Over 40 area agencies depending on availability to meet	Over 40 area agencies depending on availability to meet	MCO partners have begun to present member cases

Budget

Provide a narrative and a brief project budget outlining actual expenditures and projected costs to support the community project which must include financial reporting.

Given COVID-19 and the strain on the health safety net providers there was a shift in E5 project plans early in CY2020. The IDN1 administrative role of HUB manager was staffed for the full year but her time was adjusted to support COVID-19 community response as the Pathways Community HUB model was put on hold and subsequently discontinued due to lack of CY2020 funding. There was one aspect of the program that moved ahead and that was the expansion of Fruit and Veggie Prescription program to Valley Regional Hospital outlined in the narrative above. This is represented in the accompanying budget as food pathway payments.

Additionally, given the pause and ultimate decision not to move forward with the formal HUB project the IDN1 team amended the contracts to the core partners to enable them to leverage the awarded HUB planning dollars for their continued engagement with the Sullivan County Complex Care team and their support of the Greater Sullivan Strong COVID-19 coalition. These expenses are shown below by organizational recipient as HUB amendment.

REDACTED TABLE

Project APM: DSRIP Alternative Payment Model (APM) Implementation Planning

As a part of the DSRIP demonstration, the state has committed to value-based health services reimbursements. The DSRIP APM Roadmap articulates the process by which the state will work with the IDNs, Medicaid Managed Care Organizations (MCO), and other Medicaid services stakeholders to develop a statewide APM workgroup for the completion of the DSRIP APM Implementation Plan. The goal of the DSRIP APM Implementation Plan is to achieve 50% Medicaid provider payments in an APM by 12/31/2020.

IDNs will be evaluated on their engagement with the state and managed care plans in support of the APM goals consistent with Special Terms and Conditions (STC) 24, Project Milestones; STC 33 MCO and Medicaid Service Delivery Contracting Plan; and STC Attachment C: DSRIP Planning Protocol IV Project Stages, Milestones, and Metrics.

APM Narrative

Provide a brief narrative which speaks to the following:

- Describe how the IDN is aligning performance metrics to the MCO APMs
- Identify partners who are currently participating in or in the planning process for MCO APMs

No change to IDN1 APM activities in July-December, 2020 Term

Previous Reporting Updates: Lynn Guillette, VP of Payment Innovation at Dartmouth Hitchcock and Chair of the IDN1 Executive Committee, has been named the primary IDN1 APM liaison for the DHHS sponsored APM workgroup. Lynn, one of the leaders in the state on alternative payment models, has been integrally involved in IDN1 activities since the projects inception and served on the Exec. Committee and as chair of the IDN1 Finance Committee. The IDN1 Finance Committee under Lynn's leadership in January/February, 2018 has been relaunched to shift focus to determining the regional APM strategy and tracking alignment to the statewide plan developments.

CY 2020 Process: Given the lack of statewide APM work across IDNs the IDN1 team has adapted targets for APM support to focus on individual network partner efforts as opposed to a regional movement. The IDN1 leadership team and executive committee meet regularly to discuss APMs underway with IDN1 partners, opportunities to leverage the IDN1 network and support partners to expand billing and look at options for APM agreements. The team sees this work as a very valuable effort in pushing for project work sustainability and expanding the scope of integration within our provider practices. The IDN1 team feels that with the workgroups strong membership and regional knowledge there is expertise and drive to support APM expansion. The IDN1 team seeks to maintain coordination with statewide efforts even in the short timeframe remaining and hopes to see further developments with the Managed Care Organizations on this front.